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The Impact of Ireland's Current Mental Health Policy on the Profile of Community Mental Health Services

By

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Abstract:

In 2006, a new Government policy for mental health *"A Vision for Change"* was endorsed and is currently in the seventh year of implementation. The policy describes a comprehensive framework for building and fostering positive mental health across the entire community and for providing accessible, community based, specialist services for people with mental illness. The implementation of the policy and turning *"Vision for Change"* into reality has been problematic with considerable criticism from stakeholders concerning slow and disjointed implementation.

This study provides information on three key community mental health service settings, namely Day Hospitals, Day Centres and 24 Hour Community Residences at a national level. The research looks at aims and functions, patient profiles, therapeutic activities, effectiveness of key communication networks and gains an insight from staff on what has changed on the ground over the past seven years.

Issues identified from the three service settings pertain to all. Participants indicated that the recovery ethos appears to have moved to a more central role in patient care in the community but acknowledged that the challenge of integrating recovery principles in clinical practice remains present. The importance of individual care planning appears to be recognised in community services and respondents indicated that efforts are being made to ensure service user involvement. There were differences between 'staff views' and 'advocate views' on a number of aspects of service provision.

This is the first Irish study of its kind to examine service provision across the three main community mental health settings in one study. These services represent a huge investment in resources both on a monetary and human level. This study has examined the challenges and key issues which are applicable and impacting on all three types of service provision. It has also provided information on the elements of positive change, which are slowly embedding themselves in service provision such as the importance of the centricity of the service user and the promotion of a recovery ethos.

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Key Words: *Mental Health Policy, Community Mental Health Services, Implementation, Day Hospitals, Day Centres, 24 HR Community Residences, Service User, Individual Care Plan, Recovery Ethos, Advocacy, Therapeutic Activities, Communication.*

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Resumo:

Em 2006, foi aprovada uma nova política governamental para a saúde mental intitulada *"Uma Visão para a Mudança",* a qual está neste momento no sétimo ano de implementação. A política descreve um enquadramento para o desenvolvimento e promoção da saúde mental positiva para toda a Comunidade e para a prestação de serviços acessíveis, baseados na comunidade, serviços especializados para pessoas com doença mental. A implementação da política e o tornar a *"Vision for Change"* uma realidade têm sido problemáticos, com críticas consideráveis por parte dos intervenientes, relativas à lenta e desconexa implementação.

Este estudo fornece informação sobre as características dos serviços de três importantes tipos de instituições de saúde mental comunitária a nível nacional, nomeadamente Hospitais de Dia, Centros de Dia e residências comunitárias operantes 24 horas. A pesquisa analisa objetivos e funções, perfis dos pacientes, atividades terapêuticas, a eficácia das redes de comunicação e beneficia da perspectiva dos funcionários sobre o que mudou no terreno ao longo dos últimos sete anos.

As questões identificadas a partir das características dos três serviços dizem respeito a todos. Os participantes indicaram que o ethos da recuperação parece ter alcançado um papel mais central no tratamento do paciente na comunidade mas reconheceram que o desafio de integrar os princípios de recuperação na prática clínica se mantém presente. Parece ser reconhecida a importância da planificação do cuidado individual nos serviços comunitários e os entrevistados indicaram que existe um empenho para garantir o envolvimento do usuário do serviço. Há diferenças entre os 'pontos de vista do pessoal' e os 'pontos de vista dos representantes' sobre uma série de aspetos da prestação de serviços.

Este é o primeiro estudo irlandês deste género a examinar a prestação de serviços das três principais instituições comunitárias de saúde mental num só estudo. Estes serviços representam um enorme investimento em recursos, quer a nível monetário, quer humano. O estudo examinou os desafios e as questões fundamentais que lhe são aplicáveis e que têm impacto nestes três tipos de prestação de serviços. Também forneceu informações sobre os elementos de mudança positiva, os quais se começam a focar lentamente na prestação do serviço, assim como na importância da centralidade do utilizador do serviço e na promoção de um ethos da recuperação.

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Palavras-chave: *Política de Saúde Mental, Serviços Comunitários de Saúde Mental, Implementação, Hospitais de Dia, Centros de Dia, Residências Comunitárias 24 horas, Utilizador do serviço, Plano Individual de Cuidados, Ethos da recuperação, Advocacia, atividades terapêuticas, Comunicação.*

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Resumen

En 2006, se promocionó la nueva política gubernamental en materia de salud mental "*Una visión para el cambio"* y actualmente se encuentra en su séptimo año de implantación. La política describe un amplio marco para la construcción y el fomento de la salud mental positiva por toda la comunidad y para la prestación de servicios especializados, accesibles y comunitarios para personas con enfermedades mentales. La aplicación de la política y realización de la "*Visión para el cambio"* ha generado cierta problemática debido a considerables críticas de algunas partes por su lenta e inconexa implantación.

Este estudio facilita información sobre tres instalaciones clave de servicios de salud mental comunitarios, concretamente hospitales de día, centros de días y residencias comunitarias a tiempo completo a nivel nacional. La investigación se centra en objetivos y funciones, perfiles de pacientes, actividades terapéuticas, eficacia de las redes de comunicación clave y consigue una visión interior a través del personal sobre lo que ha cambiado sobre el terreno durante los últimos siete años.

Las cuestiones identificadas en las tres instalaciones de servicios se refieren a todo. Los participantes indicaron que el *ethos* de recuperación parece haber cobrado un papel más central en los cuidados a pacientes en la comunidad, pero reconocen que el desafío de integrar principios de recuperación en la práctica clínica sigue existiendo. La importancia de la planificación de cuidados individuales parece estar reconocida en los servicios comunitarios y los encuestados indicaron que se están realizando esfuerzos para asegurar la implicación de los usuarios de los servicios. Existen diferencias entre "visiones de personal" y "visiones de representantes" sobre varios aspectos de la prestación de servicios.

Éste es el primer estudio irlandés de este tipo para evaluar la prestación de servicios en las tres principales instituciones de salud mental comunitarias en un único estudio. Estos servicios representan una gran inversión en recursos, tanto a nivel monetario como humano. El estudio ha analizado los desafíos y cuestiones clave que se aplican e impactan en los tres tipos de prestación de servicios. También ha elaborado información sobre los elementos de cambio positivo, que se están incorporando lentamente en la prestación de servicios, como la importancia de la centralidad del usuario del servicio y la promoción de un *ethos* de recuperación.

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Palabras clave: Política de salud mental, servicios de salud mental comunitarios, implantación, hospitales de día, centros de día, residencias comunitarias a tiempo completo, usuario del servicio, plan de cuidados individuales, ethos de recuperación, representación, actividades terapéuticas, comunicación.

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“Nothing defines the quality of life in a community more clearly than people who regard themselves, or whom the consensus chooses to regard, as mentally unwell."

Renata Adler

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Chapter 1

1.0 Introduction

Ireland has a long and contentious history of providing care for its mentally ill in large, purpose built institutional settings. With the origins of institutionalisation dating as far back as the mid 1700s and spanning a period of two centuries to the mid 1900s, acceptance of the incarceration of the mentally ill was cultivated and in time, became culturally accepted. By 1900 21,000 citizens, 0.5% of the population, of the then 32 counties, were housed in district asylums (1). Walsh et al articulates *"the establishment of such a reliable economic entity in a local community, despite the popular stigmatising view of the mad and of those who looked after them, and later the apprehension that the asylum might contract and disappear, were to lead to resistence to the inauguration of alternative approaches to dealing with the problem of mental illness"* (1).

Notwithstanding a decrease in admission rates during the periods of World War 1 (1914 – 1918) and World War 2 (1939 – 1945) , admissions continued to increase during the first half of the 1900s, standing at 20,506 in 1960 for the 26 counties of the Republic of Ireland. *(See tables 1.1 and 1.2. page 16)*.

From the mid 1950s to the mid 1990s the number of inpatients in mental hospitals fell to a third of previous rates across the industrialised worId. The start time and rate of this fall varied across countries (2). This trend was also reflected in Ireland, the early 1960s saw a dramatic change in policy take place, in the manner, in which services were planned and delivered. The numbers being institutionalised also began to fall and this led to the emergence of a new philosophy on how best to care for this societal group. This marks the first milestone in the long and continuing journey of deinstitutionalisation in Ireland. Indeed, the history of institutionalisation and the ongoing journey to community focused care and treatment has passed a number of milestones, as policies and thinking changed and evolved over time.

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Table 1.1 : Number of residents in district and auxiliary hospitals at 31st December 1914 - 1962

Year	Male	Female	Total	Year	Male	Female	Total
1914	na	na	16,941	1939	10,018	9,024	19,042
1915	na	na	16,957	1940	10,057	9,077	19,134
1916	na	na	16,784	1941	9,809	8,937	18,746
1917	na	na	16,211	1942	9,477	8,654	18,131
1918	na	na	15,714	1943	9,176	8,555	17,731
1919	na	na	15,515	1944	9,090	8,516	17,606
1920	na	na	15,331	1945	9,136	8,572	17,708
1921	na	na	15,552	1946	9,143	8,648	17,791
1922	na	na	15,867	1947	9,022	8,613	17,635
1923	na	na	16,106	1948	9,178	8,816	17,994
1924	8,749	7,549	16,298	1949	9,491	8,986	18,477
1925	8,874	7,630	16,504	1950	9,580	9,097	18,677
1926	8,966	7,742	16,708	1951	9,644	9,153	18,797
1927	8,990	7,844	16,834	1952	9,817	9,250	19,067
1928	9,143	7,944	17,087	1953	10,033	9,439	19,472
1929	9,255	8,124	17,379	1954	10,189	9,545	19,734
1930	9,291	8,163	17,454	1955	10,309	9,501	19,810
1931	9,400	8,184	17,584	1956	10,457	9,606	20,063
1932	9,516	8,312	17,828	1957	10,512	9,296	19,808
1933	9,704	8,531	18,235	1958	na	na	na
1934	9,826	8,599	18,425	1959	10,574	9,016	19,590
1935	9,848	8,658	18,506	1960	10,494	8,948	19,442
1936	9,935	8,806	18,741	1961	10,279	8,798	19,077
1937	9,878	8,794	18,672	1962	10,095	8,548	18,643
1938	9,998	8,949	18,947				

na Not Available

Table 1.2 : Number of residents in private and charitable institutions 1932 - 1962

Year	Male	Female	Total	Year	Male	Female	Total
1932	319	484	803	1948	390	488	878
1933	308	483	791	1949	288	509	797
1934	308	471	779	1950	381	510	891
1935	292	472	764	1951	370	511	881
1936	293	491	784	1952	389	486	875
1937	288	475	763	1953	408	546	954
1938	285	446	731	1954	367	558	925
1939	na	na	na	1955	392	536	928
1940	na	na	na	1956	409	571	980
1941	na	na	na	1957	428	544	972
1942	267	375	642	1958	na	na	na
1943	248	391	639	1959	426	593	1,019
1944	239	375	614	1960	447	617	1,064
1945	238	359	597	1961	425	597	1,022
1946	231	330	561	1962	411	602	1,013
1947	385	497	882				

(1) p. 101 & 102

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In 1961 a Commission on Mental Illness was established to review the mental health services in Ireland and make recommendations on their improvement. The Commission's Terms of Reference were:-

(a) To examine and report on health services available for the mentally ill and to make recommendations as to the most practicable and desirable measures for the improvement of these services;

(b) To consider and report on changes which were regarded as necessary or desirable in the legislation dealing with the mentally ill (other than the legislation dealing with criminal lunatics and with the estates of persons under the care of the High Court or Circuit Court).

The Commission undertook an extensive review of mental health service provision examining in detail:-

- Trends in the Care of the Mentally Ill
- Patterns of Existing Services
- In-patient Care (short-term care, long-term care, private institutions)
- Community Services
- Provision for Special Classes e.g children, adolescents, the aged etc
- Prevention and Research
- Education and Training
- Organisation of Services
- Legislation

In 1966 the final *Report of the Commission of Inquiry on Mental Illness* (3) was published. The Report acknowledged that the measures recommended therein would require the co-operation of the Department of Health and Children, Local Health Authorities, Universities, Medical Schools, Hospital Management, Medical Professionals, Nursing Authorities, Trade Unions, Rehabilitation, Welfare organisations as well as other special groups and most especially the Irish public at large.

Undoubtedly, the work of the Commission was a major step forward for the planning of services in Ireland. The Commission, in proposing to change the image of psychiatric hospitals as the sole centres of care stated:-

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"the improvement of services and their extension into the community should make the greatest impact. Community care is undoubtedly desirable but its success depends on the development of a number of specialist facilities within the community" (3).

Notwithstanding the progressive proposals in the Report, in the ensuing years, the psychiatric hospital still largely remained the focal point of service delivery in most parts of the country.

In 1984, eighteen years later *"Planning for the Future"* (4) was published. The articulations of the 1966 report were re-affirmed in the new mental health policy document with a continued commitment to de-institutionalisation. However, *"Planning for the Future"* (4) acknowledged that institutional care was still the central means of service provision and large numbers of patients still resided permanently in psychiatric hospitals. Staff and public still tended to concentrate their efforts on hospital care and as a result community facilities remained relatively static and underdeveloped in the mid-eighties.

"Planning for the Future" (4) outlined a number of key changes which were required to shift the focus and make the move from institutional care to community care a reality, it also charted how these changes could be achieved. The report focused on the following key target areas:-

- Provision and Delivery of a Comprehensive Service
- Importance of A Community Oriented Service
- Sectorisation of Services
- Provision of In-Patient Services in Psychiatric units in General Hospitals
- Admission Policies
- Housing Programmes
- Improving Quality of Life for Patients in Psychiatric Hospitals
- Needs of Special Groups
- Staff Motivation
- Cost Implications
- Planning of Services

Specific recommendations were outlined in each of the above areas. The principles of care outlined in the policy were very relevant, and while all its recommendations were not

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implemented, it did lead to considerable improvement of services. However, as has been the case with a number of subsequent policy reports, an implementation plan was not devised in-line with the policy and therefore, change largely depended on the amount of buy-in at local level. In the absence of a roadmap in the form of an implementation plan, some services embraced the opportunity for reform while others stayed stagnant.

In the overall Irish Health Strategy *"Quality and Fairness – A Health System for You*" (5) published in 2001, it was recognised that a new mental health policy framework to build upon *"Planning for the Future"* (4) and for the further modernisation of the Irish mental health services was needed.

An Expert Group on Mental Health Policy was established in August 2003 to prepare a new national policy framework for the further modernisation of the Irish mental health services.

The terms of reference for the Group were:-

- Prepare a comprehensive mental health policy framework for the following ten year period;
- Recommend how the mental health services might be organised and delivered and
- Indicate the potential costs of implementing the recommendations.

In order to fulfil its terms of reference and in line with best practice the Group consulted in a collaborative approach with a wide a range of stakeholders. This was undertaken in four key ways:-

1. Public advertisements were placed in all the national newspapers inviting any interested parties to make written submissions to the Group. These included submissions from users of the Mental Health Services (service users), their families and carers, voluntary groups, professional groups and other services providers.
2. Questionnaires were distributed throughout the mental health services to service users.
3. Stakeholders were invited to one of two seminars.
4. The Irish Advocacy Network was commissioned to carry out an in-depth survey of service users.

The results of the wide consultation undertaken were collated and published and also used to inform the final report. The Expert Group also convened 19 advisory sub-groups to

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provide further detailed input on various aspects of the report. Over one hundred individuals were involved in the multidisciplinary sub-groups which included service users and carers where possible.

Underpinning the work that was being carried out by the Expert Group at that time in Ireland, in January 2005, the World Health Organisation produced a *Mental Health Action Plan for Europe* (6) which specified further actions to be taken by member states in twelve areas over a five to ten year period. These included mental health promotion, tackling stigma and discrimination, making specialist community based mental health services available and establishing partnerships across sectors. This action plan, "*the Helsinki Declaration"* (6)– also advocated that governments demonstrate the centrality of mental health in public health as *"mental health is central in building a healthy, inclusive, and productive society".*

In January 2006 the new Irish national mental health policy *"A Vision for Change"* (7) was published. When it was launched *"A Vision for Change"* (7) was universally welcomed as a progressive, evidence based and realistic document which proposed a new model of service delivery that would be person-centred, flexible and community based. The policy was the first in Ireland to seek to include the views of service users and carers comprehensively. The Irish Government accepted *"A Vision for Change"* as the basis for the development of the Irish mental health services for the following 7 to 10 years.

The 284 page policy document incorporates 209 recommendations and provides a blueprint for a radical approach to a newly prioritised mental health system. The policy is divided into three main sections i.e. outline of the vision underlying the policy, the plan for service developments and the process for implementing policy measures.

The report proposes a holistic view of mental illness and recommends an integrated multidisciplinary approach to addressing the biological, psychological and social factors that contribute to mental health problems. A person-centred treatment approach which addresses each of these elements through an integrated care plan, reflecting best practice, and most importantly evolved and agreed with both services users and their carers is recommended.

The Key Recommendations of *"A Vision for Change"* are outlined in Appendix 1 of this report.

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In May 2006, the Health Service Executive (HSE) which has the primary responsibility for the implementation of 80% of the Report recommendations, formally adopted the policy as the framework for the development of mental health services in Ireland. In October, 2006 a Mental Health Advisory Group was established to guide the HSE on operational policy. The HSE also established an Implementation Group to action the recommendations of *"A Vision for Change"* and to ensure that mental health services develop in a synchronised manner across the country.

The implementation of the remainder of the recommendations is the responsibility of a number of Government Departments and their agencies including: Department of Health; Department of Education and Science; Department of Enterprise Trade and Employment; Department of Environment, Heritage and Local Government; Department of Justice, Equality and Law Reform and the Department of Social and Family Affairs.

The pathway for *"A Vision for Change"* and overview of progress to date is outlined on pages 25 to 27.

1.1 Irish Mental Heath Legislative Framework

"Mental health legislation should codify and consolidate the fundamental principles, values, goals and objectives of mental health policy. Such legislation is essential to guarantee that the dignity of patients is preserved and that their fundamental human rights are protected" (8).

The "*Mental Treatment Act 1945"* (9) marked an important legislative advance in Ireland. In addition to allowing for the treatment of mentally ill persons outside hospital, it also introduced voluntary admission to a psychiatric hospital. The 1945 Act changed the process of detention: whereas previously committal to a psychiatric hospital required a decision by two peace commissioners, it became an administrative process, resting on medical certification. There was now a change in focus to ensuring that mental treatment was provided rather than just removing those with mental disorders from the community. The Act helped to remove the barrier between the community and the hospital which had existed previously.

In 1981 there was a replacement statute to the 1945 Act, (9) however, this was not brought into effect. The above was followed by a Green paper (10) (discussion) in 1992 and a White

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(proposal) paper (11) in 1995 both of which highlighted that there was a need for change in order for Irish mental health legislation to conform to international standards setting out fundamental rights. Notwithsanding this, the constitutionality of the Irish legislative regime and its compliance with the *European Convention on Human Rights and Fundamental Freedoms* was considered in the *1995 Croke v Smith case* (No 2) (12). Following both High Court *(finding in favour of Mr. Croke)* and Supreme Court *(overturning the High Court decision)* proceedings in Ireland, Mr. Croke took the matter to the European Court of Human Rights. His complaint that the regime under the *Mental Treatment Act 1945* (9) breached Article 5 of the Convention was found admissible. As part of the settlement of the case the Irish Government undertook to secure the passage of the *Mental Health Bill 1999* (13) which in time led to the enactment of the Mental Health Act 2001.

Mental Health Act 2001 (14)

A new Mental Health Act was passed in Ireland in 2001. The Mental Health Act 2001 brought legislation into line with international obligations for the protection of the rights of individuals who require compulsory admission and treatment as a result of mental illness. The Mental Health Act 2001 has introduced comprehensive human rights protections for those admitted involuntarily, leading to a high level of accountability and external scrutiny.

The Mental Health Commission (MHC), an independent statutory body, was established in April 2002, pursuant to the provisions of the Mental Health Act 2001. Section 1 to 5, 7 and 31 to 55 of the Act were commenced on 5th April, 2002.

The 2001 Act was commenced in full on 1st November, 2006. The functions of the Mental Health Commission as specified by the Act are:-

- To promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and

- To take all reasonable steps to protect the interests of persons detained in approved centres under this Act. (Section 33(1), Mental Health Act 2001).

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Specific functions of the Mental Health Commission include:-

- Appointment of the Inspector and Assistant Inspectors of Mental Health Services; The functions of the Inspectorate include visiting and inspecting each approved centre at least once annually, and to visit and inspect any other premises where mental health services are being provided as he or she thinks appropriate. (Mental health services are defined in the Act as services which provide care and treatment to persons suffering from a mental illness or a mental disorder under the clinical direction of a consultant psychiatrist).
- Appointment of persons to mental health tribunals which review the detention of involuntary patients and appointment of legal representatives for the patient;
- Establishment and maintenance of register of Approved Centres (i.e. licensing of inpatient facilities providing care and treatment for people with a mental illness or mental disorder). Currently there are 64 licensed inpatient facilities known as approved centres. This is the only area of inpatient health services provision (publicly and privately funded) in Ireland that is subject to an independent statutory inspection process and licensing.
- Making of Rules regarding specific interventions – Electroconvulsive Therapy, Mechanical Means of Bodily Restraint and Seclusion;
- Developing Codes of Practice for the guidance of persons working in the mental health services.

The remit of the Commission covers the broad spectrum of mental health services including general adult mental health services, mental health services for children and adolescents, older people, people with learning disabilities and forensic mental health services, regardless of the source of funding.

Mental health care and treatment is one of the few health areas where people can be treated on an involuntary basis. Legislation to protect the human rights of people who are detained is an essential element of a comprehensive framework for the delivery of mental health services. The commencement in full in November 2006 of the Mental Health Act 2001 provided comprehensive human rights protections for people receiving treatment and care on an involuntary basis.

In Ireland in 2011, 1471 patients were involuntarily detained, with a further 586 patients re-graded from Voluntary to Involuntary Status.

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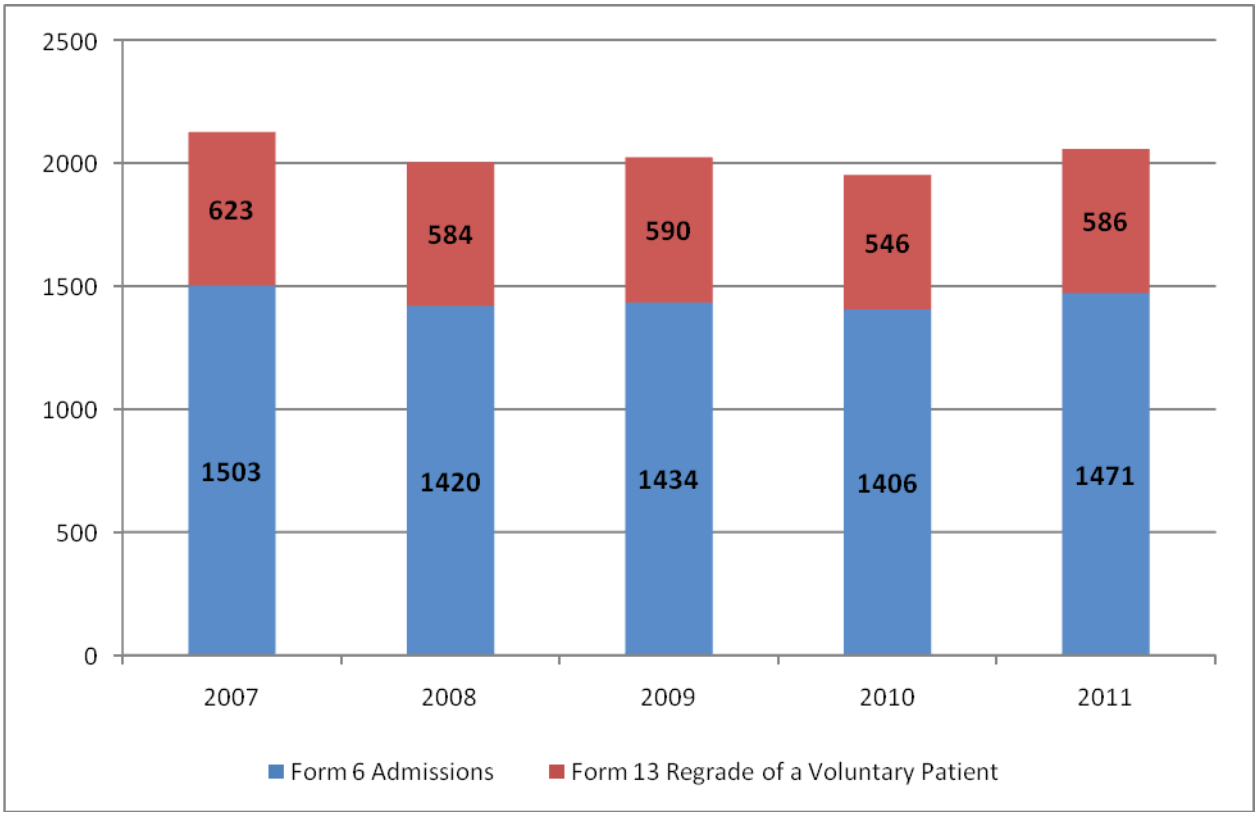
FIGURE 1: COMPARISONS OF TOTAL INVOLUNTARY ADMISSIONS 2007 – 2011



Form 6 Admission Order. Form 13, Certificate & Admission Order to Detain a Voluntary Patient (Adult)

Source: Ref (15) MHC Annual Report 2011

Since the publication of *"A Vision for Change" (7)* the Mental Health Commission has worked to support and facilitate progress with its implementation. The Commission's actions have prompted the closure of several approved centres and resulted in conditions being attached to the registration of others under the provisions of Section 64, Mental Health Act 2001. This has been the outcome of the evidence provided in the reports of the Inspector of Mental Health Services highlighting the outdated environment of many of our mental health facilities. The Commission is committed in its work to the ethos enshrined in A Vision for Change i.e. the re-orientation of the delivery of mental health services from an institutional model of care to specialist community care and treatment based on the biological, psychological and social factors that may contribute to a person's mental illness.

A review the Mental Health Act 2001 is currently being undertaken by the Department of Health in collaboration with key stakeholders. The interim Report of a Steering Group established by the Department to undertake a scoping exercise has just been published (16)

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with an Expert Group established in August 2012 to progress the second phase substantitive Review. The recommendations of the Steering Group report are provided at Appendix 2.

1.2 A Vision for Change

In 2006 a new Government policy for mental health *"A Vision for Change"* (7) was endorsed and is currently in the seventh year, of a seven to ten year implementation period. The policy describes a comprehensive framework for building and fostering positive mental health across the entire community and for providing accessible, community based, specialist services for people with mental illness.

Certainly, the past two years has represented a crucial juncture within the implementation timeframe. Slow progress to-date has been an issue of much debate and criticism by stakeholders. A 2009 report *"From Vision to Action? An Analysis of the Implementation of A Vision for Change"* (17) provides an overview of the evidence internationally that supports key specific actions, which have been shown to facilitate successful policy implementation. The key actions identified in the report have mainly been missing in the Irish context. The fundamental changes which were envisaged when the policy was developed have largely not materialised.

It must be recognised that since 2008 and in line with a global phenomena, Ireland has also been in a 'severe recession'(18). This of course, has seen debt, unemployment and levels of poverty rise, all of which have a considerable impact on resources for mental health, both at a fiscal and human resource level.

1.2.1 Independent Monitoring Group

Within three months of the publication of Vision for Change, the first of two Independent Monitoring Groups was established for a three year period (03.06 – 04.09) by the then Minister of State responsible for Mental Health, to monitor progress on the implementation of the Report's recommendations.

During its term the first Independent Monitoring Group published three Annual Reports (19), (20), (21). Issues with policy implementation were evident from the first Annual Report of the group, concerns about no implementation plan being in place and a lack of clarity in relation to responsibility for implementation were expressed. The same issues continued to

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feature in the Group's second and third Annual Reports. Three years into the policy timeframe the group were concerned that the recommendations of the first two reports had predominantly not been addressed with the absence of a dedicated leader at senior, national level obstructing progress.

The second Independent Monitoring group which was appointed in June 2009 and in June 2012 published its third and final Annual Report (22), (23), (24)

The Terms of Reference for the second Independent Monitoring Group were:-

- To monitor and assess progress on the implementation of all the recommendations in A Vision for Change;
- To make recommendations in relation to the manner in which the recommendations are implemented;
- To report to the Minister annually on progress made towards implementation the recommendations of the Report and publish the report.

In its final report the Group again emphasise that to-date implementation of *"A Vision for Change" (7)* has been slow and inconsistent. The resultant issues which have arisen due to the lack of a time-lined and costed Implementation plan are again emphasised. The group report that *"this has made it difficult to put in place a consistent framework for the development of all mental health specialities and has led to a lack of coherency in the planning and development of community mental health services" (24).*

The inadequate staffing of community mental health teams is also highlighted with an estimated 1,500 vacant posts as at June 2012, and a Moratorium in place on the recruitment of health services staff.

It is the Group's view that there is an absence of the ethos of recovery and poor development of recovery competencies in service delivery resulting in a reactive rather than a proactive approach to the needs of individuals and their families. The Group recommend that a cultural shift on how mental health services are delivered is required, moving from professional dominance to a person-centred , partnership approach.

The report also recommends that the implementation of "*A Vision for Change"* should be subject to continued monitoring over the next four years.

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1.2.2 Political Commitment to Vision

In early 2011, a new Government was elected, whose programme for government entitled *"Government for National Recovery" (25)* committed to:-

- **Ring fencing €35m a year for the development of community mental health teams and services;**

- Establishing a cross-departmental group to integrate good mental health policy into other areas;

- Endeavouring to end the practice of placing children and adolescents in adult wards; and

- Bringing in new legislation on mental capacity in line with the UN Convention on the Rights of Persons with Disabilities to ensure the greatest degree of autonomy for people with intellectual disabilities or with mental illnesses.

- Reviewing the Mental Health Act 2001.

As detailed earlier a Review of the Mental Health Act 2001 is currently underway.

The special Governmental allocation of €35 million which was provided for in 2012 primarily to further strengthen Community Mental Health Teams in both adult and children's mental health services has been welcomed by stakeholders. However, the filling of the required posts was then delayed until December 2012. Notwithstanding this funding appears to have been preserved, and in addition to the €35 million allocated for 2013 this means that €70m is now allocated for spending on community mental health teams in 2013. This allocation of additional funding will assist the expansion of activities in the areas of suicide prevention, initiate the provision of psychological and counselling services in primary care, specifically for people with mental health problems and facilitate the re-location of mental health service users from institutional care to move independent living arrangements in their communities. The 414 posts approved to implement this package of measures is also a positive development.

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1.3 Mental Health Community Service Settings

In Ireland, mental health services activity principally takes place in publicly funded community service settings. People with mental health problems are usually seen in outpatient settings, in day hospitals, day centres or in their own home. It is a minority of people who will require inpatient care. The Health Research Board Report, *Irish Psychiatric Units and Hospitals Census 2010* (26) reports that there were 2,812 patients resident in Irish psychiatric units and hospitals on 31st March, 2010, representing a hospitalisation rate of 66.3 per 100,000 total population. This is a reduction in the number 3,389 and rate (86.5 per 100,000 total population) of patients since 2006 and a reduction of 86% in in-patient numbers since 1963.

As outlined earlier historically, care and treatment provision for the mentally ill in Ireland has been institutionally based, resources, be they, staffing, financial or other, have mainly been directed towards inpatient care. Overall, there is a dearth of information on mental health services. To-date, the data that is available, gives much more information on in-patient services than community mental health services.

1.3.1 Day Hospital Service Provision

Day hospitals are concerned with medical care in the broad sense, in contrast to day centres, which are largely concerned with social care. Day hospitals offer an alternative to in-patient admission for a percentage of service users. Social and psychological therapy programmes are offered in addition to medication for people with acute mental disorders whose needs can be met in a hospital setting. There is evidence that acute day hospital facilities are suitable for a quarter to a third of service users who would otherwise be admitted to hospital (7), (27),(28). With regards to adult mental health service provision *"A Vision for Change"* (7) highlights the serious dearth of suitable community based facilities for the delivery of high quality care. This applies to community mental health centres, day hospital accommodation and community residences. Notwithstanding this, the policy also states that there is evidence that many day hospitals in Ireland are not providing the same treatments that are available in an acute in-patient setting and therefore not offering an alternative to acute in-patient care (7), (29).

A seminal study was undertaken in 2003 by Hickey et al (2) to examine the extent of day hospital and day centre service provision and function in two health board areas in Ireland. Pertaining to Day Hospitals, a number of the key findings of the study were (i) day hospitals

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in the two areas were generally not providing a service for acutely ill patients (ii) a comprehensive range of treatments were not available in day hospitals within the two areas (iii) there was very limited community-based crisis intervention services for patients outside office hours and (iv) most patients attending day hospitals were experiencing relatively mild mental illness. The study also made a number of recommendations and proposed guidelines for services.

Briscoe et al (30) undertook a national survey of psychiatric day hospitals in the UK, the findings of which were published in 2004. The findings of the study of 102 days hospitals confirmed that there is great heterogeneity in English day hospital service provision .

The English study undertaken by Briscoe et al (30) formed part of an overall European study comparing psychiatric day hospitals in five European countries undertaken by Kallert et al (31) also published in 2004. National studies took place in Germany, England, Poland, the Slovak Republic and the Czech Republic.

1.3.2 Day Centre Service Provision

"Planning for the Future" (4) Ireland's mental health policy which preceded *"A Vision for Change" d*efined the role of the psychiatric 'Day Centre' as follows:-

"The role of the psychiatric day centre is to provide social care for patients... the day centre may also offer treatment. Rehabilitation and activation services may be provided and these could include occupational therapy, social skills training and light industrial therapy".

The current policy *"A Vision for Change"* largely retains this definition. One of the biggest difficulties in commenting on studies which have looked at the role of day centres, is the heterogeneity of what defines a 'day centre' in Ireland in comparison to other jurisdictions.

Research has shown that rates of unemployment among people with mental disorders are usually much higher than in the general population (32), (33) and that traditional methods of occupation and day care have been provided by day centres[ii] A systematic review undertaken by Marshall et al (27) found that there has been little scientific research into traditional forms of day care, and a review of over 300 papers found no relevant randomised control trial.

As already referenced the study by Hickey et al (29) did examine the purpose and function of day centres in two health board areas in Ireland in 2003. Pertaining to Day Centres some

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of the key findings were: (i) the majority of day centres premises were unsuitable for their intended purpose; (ii) there was a variety of referral procedures and (iii) there appeared to be a low level of activity in day centres.

1.3.3 24 Hour Community Staffed Residences

In Ireland the move from institutional care to community based care resulted in community residences being opened throughout the country to house people who had previously been long term residents of psychiatric hospitals. Those who cannot live independently without support are also housed in these residences. In 2006 *"A Vision for Change"* (7) put the number of community residential places at 3,000. This number would include low, medium and high support residences.

Focusing on 24-hour staffed residences the policy purports that these residences will decrease once the cohort of former long stay hospital service users has been catered for. It is estimated that in the long term, there will be a requirement of approximately 30 places in large urban areas, with fewer required in areas of low deprivation. The policy supports the residences should have a maximum of ten places and cultivate a non-institutional environment.

In 2007 a study was undertaken by Tedstone et al (34), this was a survey and evaluation of community residential mental health services in three geographical regions covering eight catchment areas. Out of a total of 138 residents interviewed for the study, 59% were in high support residences. The study found that the rate of provision of places at 76 per 100,000 was considerably higher than recommended by current policy. This report also made a number of recommendations on the way forward for service provision. Six years after its publication very few of the recommendations have been acted upon and community residences remain on the periphery of service provision, notwithstanding the high numbers who reside in them.

1.4 Moving forward in a Changing Landscape – Contribution of this Study

To move forward we need to examine our current position in this time of flux and change. This study has looked at three key community mental health service settings Day Hospitals, Day Centres and 24 HR Staffed Community Residences. Rather than focusing on particular catchment areas, this study aims to provide a national representation of these

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services looking at their aims and functions, patient profiles, therapeutic activities, effectiveness of key communication networks and gaining staff insight on what has really changed on the ground over the past seven years. These services represent a huge investment in resources both on a monetary and human level. However, over the past seven years much focus has still been on in-patient mental health service settings. Under current legislation only in-patient mental health services in Ireland are registered with and licensed by the Mental Health Commission. Any amended legislation will need to address this and broaden the remit of the Commission to also license community mental health services.

In Ireland data on Irish psychiatric units and hospitals is collected routinely, however, information for community services is not available at a national level, including information on the number, range and geographical location. Data is also not routinely collected on the numbers of people resident, admitted and discharged from 24 HR staffed Community residences or for the number of people using mental health day hospitals or day centres.

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“Mental illness is nothing to be ashamed of, but stigma and bias shame us all."

Bill Clinton

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Chapter 2

2.0 Literature Review

Mental health disorders constitute 13% of the global burden of disease, surpassing both cardiovascular disease and cancer (35). By 2020 it is estimated that they will account for 15% of total disability (36), (37). Costs associated with mental health disorders are considerable, with 60-80% of costs occurring outside the health system and attributed to lost employment, premature retirement and poor performance at work (38) (absenteeism, presenteeism). Despite this, the development of mental health policies and the promotion of mental health, is not prioritised adequately in many countries, with little focus on the environmental and social consequences of mental ill-health (38). In addition the burden of mental disorders is likely to have been underestimated because of inadequate appreciation of the connectedness between mental illness and other health conditions.

Over the last number of years, there has been considerable debate internationally on the provision of mental health care and the move from hospital based service provision to a community based care. Robust evidence has emerged internationally that the institutional model of service provision resulted in poor standards of care and treatment (39). Well managed and planned discharge from in-patient settings to community care settings, results in more favourable outcomes for most patients (40), (41), (42) and transfer of care from institution to the community has been shown to be successful when properly funded and supported (39).

Current consensus has moved towards a balanced care approach to the provision of mental health care, with evidence supporting a combination of acute hospital care
where necessary, but an overall emphasis on services in the community that include accessible out patient clinics (OPD), community mental health teams (CMHTs), both generic and specialized, ambulatory clinics, home-care teams and acute day hospital (42), (43), (44). UK experience suggests that the generic, non-specialized CMHT results in greater engagement with services, greater carer satisfaction and higher levels of met needs (44), (45), (46), (47). Within the paradigm of CMHTs, services offered can be specialised by providing assertive community teams, early intervention teams and home treatment teams,

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amongst others. Home-based teams essentially offer an alternative to acute admission and evidence would suggest that they reduce the number of days spent in hospital by those with acute mental illnesses (48), (49). There is no evidence to support the view that care can be provided without acute hospital beds (43).

There is a widespread international consensus that the provision of mental health services should be needs-led rather than service led, that care should be delivered through community and general health settings rather than through large institutions (50), (51) and that resource allocation should follow need (52) rather than historical precedent or political judgment, as would currently appear to be the case.

Thornicroft and Tansella propose a matrix model (53), whereby provision of care is viewed along two dimensions - the geographical and the temporal. Within these dimensions, there are three geographical levels (country/regional, local and patient) and three temporal levels (inputs, processes and outcomes). The centricity of the service user in service provision and the delivery of a needs based service which is also evidence based is now widely recognised.

We can say then that it is now widely accepted that the provision of mental health care and treatment should always be provided in the least restrictive, least stigmatising environment. Most people with mental health difficulties prefer to be treated in their own community (54), (55). In-patient mental health care should only be required for a small percentage of people experiencing acute mental health difficulties and for the minimum amount of time required therapeutically. In the UK and elsewhere there is now a growing preference for acute home-based care delivered by specialised crisis teams as an alternative to hospital admission. According to a recent systematic review, home-based care is thought to be feasible for approximately 55% of service users who otherwise would be admitted. Such care also appears to reduce costs and increase satisfaction (56). The manner in which mental health care and treatment is provided continues to move through a transitional phase in Ireland. As we navigate through this change we must be mindful that not all change is innovation. To be a worthwhile innovation (not simply a 'change') a service development must demonstrate that it produces better outcomes than that which precedes it. Not only that, it must be sustainable (2).

Ireland's national mental health policy *"A Vision for Change"* (7) was adopted by government at the end of 2005 and formally launched in January 2006. The policy describes a

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comprehensive framework for building and fostering positive mental health across the entire community and for providing accessible, community based, specialist services for people with mental illness. The central theme of "*A Vision for Change"* is the need for a new paradigm in the delivery of mental health services; Service providers should work in partnership with service users and their families and facilitate recovery and reintegration through the provision of accessible, comprehensive and community-based mental health services.

The Health Service Executive in 2012 in their Guidance Paper on Community Mental Health Services (57) set out the following targets for change:-

1. Establishment of complete community mental health teams

2. Rapid access to emergency assessment in the community and prompt access to routine assessment

3. Availability of day hospital care and treatment on a seven day a week basis

4. Improved effectiveness and efficiency of care and treatment through implementation of clinical programmes in mental health

5. Significant reduction in acute inpatient admissions

6. Significant reduction in length of stay for acute inpatient admissions

2.1 Day Hospital Service Provision

Notwithstanding the growth of community care, many people with acute psychiatric disorders continue to be treated on an inpatient basis (58). There are high cost implications associated with the provision of inpatient beds (59) and surveys indicate that it may often be unnecessary (60). It has been proposed that many people who are currently treated as inpatients could be cared for in acute psychiatric day hospitals (61).

The acute day hospital has been defined as a day hospital that provides "diagnostic and treatment services for acutely ill patients who would otherwise be treated on traditional psychiatric inpatient units" (62). Supporters of Day Hospital care propose that it can provide cost-effective care by promoting quicker recovery (63), improving social functioning (64),

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(65), reducing family burden (61) shortening the duration of hospital care (66), and reducing relapse rates (67). However, the large number of patients lost to follow-up in day hospital studies has also been highlighted (68) and have questioned whether day hospital treatment may actually "institutionalise" patients by encouraging them to attend for overlong periods of time (69).

"Planning for the future" (4) the former mental health policy for Ireland noted that 'the function of the Day Hospital is to provide intensive treatment equivalent to that available in a hospital inpatient setting for acutely ill patients'. *"A Vision for Change"* (7) the current policy developed this definition further stating that 'day hospitals offer and alternative to in-patient admission for a proportion of service users'.

A Systematic Review by Marshall et al identified (27) randomised controlled trials of acute day hospital treatment involving 2268 service users. The Review found that treatment in Day Hospitals was feasible for at least 23%, and at most 38% of service users admitted to hospital and led to cost reductions raning from 20.9% to 36.9% over in-patient care. Other research also purports that between 30% and 40% of acutely ill service users could be solely treated in Day Hospitals.

2.2 Day Centre Service Provision

The principal focus of day centres is to provide social support for individuals who have chronic and enduring mental health presentations and to support rehabilitation, social inclusion and recovery. In 2005 the WHO Health Evidence Network Synthesis Report (70) looked at how effective different types of day care service are for people with severe mental disorders. The report defined a 'Drop-in Centre' as a 'non-clinical environment where people with mental disorders can go for social support and activities'. The report (70) provides details of a Cochrane review published in January 2001 (71) which evaluated the effectiveness of drop-in centres to facilitate recovery and maintenance of long-term patients in the community. While the Cochrane review used the term 'day care centre' the function and structure of centres in the included studies corresponded to the Health Evidence Network report definition as outlined above. The Cochrane review outlined no relevant randomised controlled trials concluding that there was no evidence on the effectiveness of drop-in centres from randomised controlled trials.

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As referenced in the Introduction a seminar study by Hickey et al (29) examined the purpose and function of day centres in two health board areas in Ireland in 2003. Pertaining to Day Centres some of the key findings were: (i) the majority of day centres premises were unsuitable for their intended purpose; (ii) there was a variety of referral procedures and (iii) there appeared to be a low level of activity in day centres.

2.3 24 HR Staffed Community Residences

The Mental Health Commission and HRB Report (34) published in 2007 highlighted the number of people who were living in community residences in Ireland. In 2004 the number of people in low, medium and high support residences was 3,065.

These had previously been long stay patients of psychiatric hospitals that in line with mental health policy (4) and the move from institutional to community based care had been re-located to alternative accommodation in community residences.

The report (34) outlines the rationale for the strategy i.e. that community residences would fulfil a therapeutic and rehabilitative function such that persons with persistent mental illness would move from higher to lower levels of support and where possible to complete independence.

"A Vision for Change" (7) recognised that the programme had a limited vision of rehabilitation and recovery, in essence becoming more of a re-settlement and maintenance programme. Vision (7) states that the need for 24-HR staffed community residences will decrease once the cohort of former long stay hospital service users has been catered for. However, this still represents a significant number, details of the profile for 30 24 HR Residences is provided in Chapter 4 of this Report.

2.4 Implementing Mental Health Policy in Ireland

A Policy which is embraced by a Minister, approved by Cabinet, announced publicly, but inadequately delivered is worse than no policy at all.." (72). The 'implementation gap' has been of concern to many western governments in the latter part of the 20th century (73).

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A possible contributing factor to the implementation gap is the failure to grasp the complexity of the implementation process. While much effort is focused on the formulation of policies, plans and programmes which will bring about change, little attention it given to their implementation. The need for specific skills and competencies in implementation is often not recognised.

Although there is a considerable amount of literature on the theory and practice of implementation, there is relatively little practical guidance on what approaches lead to effective implementation. This lack of evidence based guidance is happening at a time when politicians and policy-makers are more focused than every upon the challenges of implementation.(74)

An important and consistent point which emerges from implementation literature is the importance of leadership to successful implementation (74) (75) . The key requirement is identified as a senior officer who is accountable for the delivery of the policy and has the appropriate authority, skills and resources to do so. In terms of the specific skills required of the person leading implementation, it is noted that this is not a matter to be left to chance, or to learning on the job (76).

However, a single leader alone is not sufficient to ensure effective implementation. The leadership model described by the evidence is one that includes a skilled leader, supported by a team with the necessary skills, knowledge and experience, and including someone with financial expertise. The financial expertise is often overlooked and of great importance. It is worth noting that there are no costs attached to any of the many actions listed in the HSE Implementation Plan for *"A Vision for Change" (7).* Neither is there any clarity on how the actions will be funded.

It has been acknowledged by the HSE that funds allocated to mental health were used to cover gaps in other areas of the health service. Close to full funding for *"A Vision for Change"* was provided in 2006 and 2007 (€26.2 million in 2006 and 25 million in 2007). Although €30 million has now been spent, there is little evidence of significant improvements in the range of and quality of mental health services available to service users (74), (77).

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2.5 Contribution of this Study

This study looks at what impact “A Vision for Change” (7) has had on community mental health services at grassroots level. There is a dearth of information on these services, particularly, at national level. Indeed, the most basic requirement of putting together a comprehensive list of these services was not without its challenges for the Researcher. This information is not readily available at a time when value for money and funding of services is critical.

In Ireland we are now 47 years advocating for community mental health services. This study provides information on three key community mental health service settings (i) Day Hospitals, (ii) Day Centres and (iii) 24 Hour Community Residences at a national level. This is the first study which attempts to examine service provision across these three settings in one study. It provides an opportunity to examine the challenges and key issues which are applicable and impacting on all three types of service provision. It also provides information on the elements of positive change which are slowly embedding themselves in service provision such as the importance of the centricity of the service user and the promotion of a recovery ethos.

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Chapter 3

3.0 AIMS OF THE STUDY

1. To provide a national profile of day hospital & day centre service provision. This was undertaken to ascertain the aims, organisational structure and content of service provision.

2. To map the current service provision profile of day hospitals and day centres to the conceptual model as outlined in "A Vision for Change" (7).

3. To provide a profile of 24 hour staffed community residences

5. To elicit the views of Peer Advocates on Community Mental Health Services

   nationally and in particular Day Hospital and Day Centre service provision..

3.1 Methodology

This study was undertaken using a mixed method design (78), which is a procedure for collecting and analysing both quantitative and qualitative data in order to understand a research problem more completely (79). When used in combination, quantitative and qualitative methods complement each and allow for more complete analysis (80) . Mixed method design is particularly attractive in the healthcare context due to its ability to collect comprehensive information about a phenomenon that can guide decisions about practice. The quantitative data was obtained through an enumeration of day hospitals, day centres and through a sample of 24 hour community residences nationally.

The qualitative data was gathered using (i) Peer Advocate questionnaires, and (ii) the adaptation of the survey instrument questionnaires to include questions which allowed respondents to give their own views on mental health policy in Ireland.

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3.2 National Profile Day Hospitals

3.2.1 Measures

The survey instrument used was a 30-item questionnaire based on and adapted from the 15-item questionnaire which was used by Briscoe et al in their 'National Survey of UK Psychiatric Day Hospitals' (30) and Kallert et al in their study 'A Comparison of Psychiatric Day Hospitals in Five European Countries' (31). The questionnaire is available at Appendix 4 of this Report.

Respondents were asked to rate the relative importance of eight service aims or functions on a five-point Likert scale (1 = no importance, 5 = most important); to record which of a list of possible Exclusion Criteria were applied in their Day Hospital and to describe their patients (in terms of diagnostic categories), their staff and details about the treatment programmes available. The survey also included questions about the location of the Day Hospital and patients attendance. 12/30 questions focused on eliciting the views of Day Hospital staff pertaining to areas of Communication and Mental Health Policy.

3.2.2 Data Collection

A total of 62 functioning Day Hospitals were identified nationally and a contact person, usually the Clinical Nurse Manager II identified at each Day Hospital.

The Researcher e-mailed each CNMII providing the background to the study and inviting them to participate. The questionnaire was e-mailed directly to the identified contact person. Assertive action was taken to improve the response rate. Unreturned questionnaires were followed up by telephone at regular intervals and duplicate copies sent when required.

3.2.3 Results

A total of 46 questionnaires were completed, giving a response rate of 74%.

The data was analysed using SPSS (PASW Statistics 18). All of the findings reported in Chapter 4 Part A are based exclusively on the information provided by the Day Hospital respondents.

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3.3 National Profile Day Centres

3.3.1 Measures

The survey instrument was a 26-item questionnaire again, largely based on the 15-item questionnaire which was used by Briscoe et al in their National Survey of UK Psychiatric Day Hospitals (30) and Kallert et al in their study *"A Comparison of Psychiatric Day Hospitals in Five European Countries"* (31) as a considerable number of the questions also had high validity for Day Centre Service provision. The questionnaire is available at Appendix 5 of this Report.

Respondents were asked to list and rate the relative importance of the aims and functions of their Day Centre on a five-point Likert scale (1 = no importance, 5 = most important); to describe their patients (in terms of diagnostic categories), their staff and details about service user attendances, therapeutic activities and referrals. As with the Day Hospital survey, the Day Centre Survey also included questions about the location of the Day Day Centre, with 10/26 questions focused on the areas of Communication and Mental Health Policy.

3.3.2 Data Collection

A total of 44 functioning Day Centres were identified nationally and a contact person, usually the Clinical Nurse Manager II identified at each Day Centre.

As with the Day Hospitals, the Researcher e-mailed each CNMII providing the background to the study and inviting them to participate. The questionnaire was e-mailed directly to the identified contact person.

Assertive action was taken to improve the response rate. Unreturned questionnaires were followed up by telephone at regular intervals and duplicate copies sent when required.

3.3.3 Results

A total of 29 questionnaires were completed, giving a response rate of 65%.

The data was analysed using SPSS (PASW Statistics 18). All of the findings reported in Chapter 4 Part B are based exclusively on the information provided by the Day Centre respondents.

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3.4 24 Hour Community Based Residences

3.4.1 Meausures

The survey instrument used was a 'Facility Questionnaire' used in the Mental Health Commission / Health Research Board study on Community Residential Mental Health Services in Ireland (72). As with the Day Hospital and Day Centre Questionnaires, the survey instrument questionnaire was adapted to include a number of questions focused on mental health policy.

The survey instrument also included questions pertaining to: (i) Rules & Regulations, (ii) Meals, (iii) Staff, (iv) Admission Procedures, (v) Evaluation Process and Procedures, (vi) Resident Characteristics, (vii) Community Integration. The questionnaire is available at Appendix 6 of this Report.

3.4.2 Data Collection

Unfortunately there was no complete and concise list of 24 HR Staffed Community Residences which could be obtained for this study. The Researcher through various sources compiled a list and from this it is estimated that there are in the region of 120 24 HR Staffed Community Residences in Ireland.

The Researcher e-mailed where possible and wrote to in cases of no e-mail connection in the residence each CNMII providing the background to the study and inviting them to participate. The questionnaire was posted and in some cases e-mailed directly to the identified contact person. Assertive action was taken to improve the response rate. Unreturned questionnaires were followed up by telephone at regular intervals and duplicate copies sent when required.

3.4.3 Results

A total of 30 questionnaires were completed, giving a response rate of approximately 25%. The data was analysed using SPSS (PASW Statistics 18). All of the findings reported in Chapter 4 Part C are based exclusively on the information provided by the 24 HR Staffed Community Residence Respondents.

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3.5 Peer Advocate Feedback

The Irish Advocacy Network (IAN) in Ireland is a Peer Advocate organisation, the IAN have 18 Peer Advocates working nationally in both in-patient and to a lesser extent in community mental health service settings. The Researcher contacted the Chief Executive Officer of the Ian and provided the background to the study with a request to make contact with the Advocate network. IAN agreed to the distribution of the questionnaire. The questionnaire is available at Appendix 7 of this Report.

3.5.1 Measures

A questionnaire was developed by the Researcher to elicit the views of Peer Advocates on Community Mental Health Services in Ireland.

3.5.2 Results

A total of 7 Peer Advocates participated in the study by completing the questionnaire. This represented a response rate of 38%.

The views of the Peer Advocates are provided in Chapter 4 Part D of this report.

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Chapter 4

4.0 RESULTS - PART A - DAY HOSPITAL SERVICE PROVISION

"Planning for the future" (4) the former mental health policy for Ireland provided that 'the function of the Day Hospital is to provide *intensive treatment equivalent to that available in a hospital inpatient setting for acutely ill patients'. "A Vision for Change"* (7) the current policy developed this definition further stating that "day hospitals offer and alternative to in-patient admission for a proportion of service users".

The following data represents the findings from a 30 question questionnaire issued to Day Hospitals nationwide for a study in which 46 Day Hospitals participated. The questionnaire was for the assessment of both structural and procedural variables of Day Hospitals. (See Appendix 4).

4.1 Sample Characteristics

Respondents indicated that the profile of the local catchment areas served by the Day Hospitals were as follows: 47.8% Urban, 36.9% a combination of urban, suburban and rural areas, 8.7% Suburban and 6.5% Rural. Respondents indicated that in their local catchment area there was a Mean of 1.84 (s.d 1.537) Day Hospitals and 1.17 Mean (s.d .568) Approved Centres (Psychiatric Hospital or Acute Psychiatric unit within a General Hospital).

4.1.1 Location of Day Hospital

63% of Day Hospitals were located more than 15 minutes from an Approved Centre. 58.7% indicated a Mean time of 36.48 minutes (s.d 11.67) travel time by public transport from the Approved Centre. 4.3% of Day Hospitals were located inside the hospital grounds, 6.5% on the hospital grounds, 8.7% next to the hospital grounds and 15.2% within 15 minutes from the Hospital by public transport.

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4.2 Organisation & Structure

43.5% (n = 20) of Day Hospitals reported that they had a fixed number of places available with a mean of 16.55 (s.d = 9.553) places. The remaining Day Hospitals did not have a fixed number of places 56.5% (n = 26)

The majority of Day Hospitals in Ireland offer a service from Monday to Friday. However, some areas have commenced a weekend service. In total 17% (n = 8) Day Hospitals had a service available at the weekend i.e. 8.7% (n = 4) indicated that 'Service Users were expected to attend the Day Hospital Monday to Friday and if necessary, at the weekends too' and again a further 8.7% (n = 4) indicated that 'Service Users attend the Day Hospital depending on their needs and if necessary at the weekends too'.

Of the services that did not have weekend service available 65.2% (n = 30) indicated that Service Users attend based on 'their individual needs (Monday to Friday). 15.2% (n = 7) responded that Service Users were expected to attend the Day Hospital 'Monday to Friday'.

58.7% (n = 27) of Day Hospitals were open from 9:00am to 5:00pm, there was a variation of timings close to the above for a further 24% (n= 11). In addition, 2.2% open from 8:30am – 7:30pm, 2.2% open from 9:00am to 7:30pm and 4.3% open 8:00am to 4:30pm.

87% (n = 40) did not have a set minimum time that Service Users were required to attend the Day Hospital. 13% (n = 6) responded that Service Users were expected to attend the Day Hospital for a minimum time daily i.e. 4.3% = 2 Hrs daily, 4.3% = 4 Hrs daily and 4.3% = 6 Hrs daily.

71.7% (n = 33) of Day Hospitals were established in existing premises, with 28.3% of Day Hospitals (n = 13) being purpose built.

65.2% (n = 30) of Day Hospitals provided the year that their Day Hospital service commenced. The longest established service commenced in 1977, with the most recent established in 2012. Responses confirmed that 17 Day Hospitals had been established between the years of 2000 and 2012.

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Table. 2: Day Hospitals – Year Service Commenced:

DH YR Service Commenced		Frequency
Valid	1977	1
	1980	1
	1981	1
	1987	1
	1988	2
	1989	1
	1990	1
	1992	2
	1995	2
	1997	1
	2000	4
	2002	1
	2003	2
	2005	3
	2006	1
	2007	3
	2011	2
	2012	1
	Total	30
Missing	System	16
Total		46

4.2.1 Day Hospital Premises

Respondents were asked to provide a brief description of their Day Hospital premises, these varied considerably. 76% (n = 35) provided the information. To give the reader an insight these have been detailed below in Table 3.

Table 3: Day Hospitals – Description of Premises

Day Hospital Premises – Brief Profile / Description	**%**
Part of Primary Care Setting – 10 Rooms	2.2%
Old Style Psychiatric Hospital	4.3%

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Long Corridor with Group room and offices off same	2.2%
Located first floor of three story building. 3 group rooms, 9 single interview rooms, disadvantaged area of city.	2.2%
5 consulting rooms, rooms for acute nursing team, OPD, Med Team +++ cramped and overcrowded	2.2%
Rented private residential dwelling	4.3%
3 story detached house in hospital grounds	2.2%
Former convent / nursing home	10.9%
Middle and end of terrace two-story building. Various rooms accessed by Therapists	2.2%
Renovated building 4 rooms and offices, therapist room and gym	2.2%
Old converted house on hospital grounds	2.2%
Part of former local district hospital	2.2%
Town Centre building, grossly overcrowded, no waiting rooms, unsuitable as generic sector HQ	2.2%
Purpose built building, rooms for multid team, group rooms, activity room	2.2%
2 Large meeting rooms, 1 staff office, kitchenette, 2 toilets, clinic room	2.2%
First and second floor of building above commercial unit	2.2%
Clinical room, nursing office, sitting room, group room, kitchen, dining room, garden	2.2%
Converted former residential dwelling	4.3%
Rented unit on hospital grounds	4.3%
Part of late 18th century building – refurbished early 1990s	2.2%
One Story pora-cabin	2.2%
ST and DH recently located to new purpose build premises part of local PCC	2.2%
Purpose built community unit incorporating care of the eldery and palliative unit	2.2%
2 story building developed as CMH facility	2.2%

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4.2.2 Adequacy of Day Hospital Premises to Meeting Service Needs

Day Hospitals were asked to rate if their premises were adequate to meet Service Needs on a Likert Scale of 1 to 5, with 1 representing 'Not Adequate' and 5 representing 'Meets Service Needs Well'. The Highest rating was the mid-scoring of 3 on the scale with 32.6% assigning that score and indicating that their premises were 'adequate' to meet their Service Needs. 45.7% (n = 21) represents a combined rating for Day Hospitals indicating that their Premises 'Meets Service Needs Well' or 'Meets Service Needs'. 10.9% of Day Hospitals indicated that their premises were 'Reasonably Adequate' to meet Service Needs and 10.9% of Day Hospitals indicated that their Day Hospital premises was not adequate to meet Service Needs.

Table 4 : Adequacy of Day Hospital Premises to Meet Service Needs

		Value	Count	Percent
Standard Attributes	Label	Q6 How DH meets Service Needs		
N	Valid	46		
	Missing	0		
Labeled Values	1	Not Adequate	5	10.9%
	2	Reasonably Adequate	5	10.9%
	3	Adequate	15	32.6%
	4	Meets Service Needs	12	26.1%
	5	Meets Service Needs Well	9	19.6%

4.2.3 Access to Crisis Houses

10.9% (n = 5) of Day Hospitals reported that they had access to a Crisis House, with 89.1% (n = 41) responding that such a service was not available to them.

4.3% (n = 2) of the Day Hospitals indicated that there were plans for a Crisis House to be established, with 84.8% (n = 39) with no future plans for such a facility.

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4.3 Aims & Functions of Day Hospital

Mean ratings for aims and functions of Day Hospitals are shown in Table 5 below. The aim with the highest mean rating was 'Providing an Alternative to In-Patient Care' (mean = 4.63, s.d. = .711) with 71.7% of respondents rating this function of greatest importance and 23.9% rating it of great importance.

Table 5: Mean Ratings for Aims & Functions of Day Hospitals

Aims & Functions of Day Hospital	N/ DH	Mean (s.d.)	5 Greatest Importance	4 Great Importance	3 Medium Importance	2 Moderate Importance	1 No Importance
Service to shorten inpatient treatment	44	4.36 (.892)	56.5%	21.7%	13%	4.3%	0%
Alternative to inpatient treatment	46	4.63 (.711)	71.7%	23.9%	0%	4.3%	0%
Used for Outpatient Clinics	43	3.53 (1.517)	34.8%	21.7%	13%	6.5%	17.4%
Addition to Outpatient Treatment	45	4.36 (1.090)	60.9%	23.9%	6.5%	0%	6.5%
Crisis Intervention	45	4.49 (.727)	58.7%	30.4%	6.5%	2.2%	0%
Psychotherapy	44	3.80 (1.268)	37.0%	26.1%	15.2%	10.9%	6.5%
Rehab for Chronic Disorders	45	3.80 (1.268)	19.6%	23.9%	17.4%	21.7%	15.2%
Social Rehab							

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and Support	45	3.56 (1.271)	30.4%	21.7%	23.9%	15.2%	6.5%
Other	13	4.00 (1.528)	17.4%	2.2%	4.3%	0%	4.3%

4.4 Patient Exclusion Criteria

The reasons reported as exclusion criteria for patients from day hospital treatment were Intellectual Disability (37%), Organic Disorders (28.3%) and Drug addiction / Substance Abuse (23.9%), Other (30.4%),

In addition to the above other reasons for exclusion were acute suicidal ideation (15.2%), acute psychotic decompensation (10.9%), too long a distance from the Day Hospital (8.7%) and no motivation (6.5%).

4.5 Routine Diagnostic Procedures Applied in Day Hospitals

Day Hospitals were asked to indicate what Diagnostic Procedures were routinely applied in the Day Hospital. 93.5% of Day Hospitals indicated that they undertook Collatoral History Interviews with Relatives, 78.3% took Blood Tests, 71.7% undertook Psychological Tests, 52.2% Urine Tests, 23.9% undertook Physical Examinations, 19.6% Neurological Examinations and 50% responded yes to an 'Others' option but did not specify.

4.6 Characteristics of Patients

During 2011, the majority of Day Hospitals treated service users with diagnosis of Affective Disorders Mean % 43.95, Schizophrenia Mean % 21.91 and Schizo-affective disorders Mean % 14.55. Tables 6 provides further details.

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Table 6 : Day Hospitals - Main Diagnosis of Service Users in 2011

		Q16 DH 2011 % Organic Disorders	Q16 DH 2011 % Addiction/ Abuse	Q16 DH 2011 & Schizophrenia	Q16 DH 2011 % Schizo-affective disorders	Q16 DH 2011 % Affective Disorders
N	Valid	15	20	28	31	30
	Missing	31	26	18	15	16
Mean		12.985	8.570	21.918	14.552	43.950
Std. Deviation		16.0681	6.3224	18.4229	15.7744	17.4288
Range		50.0	21.0	84.0	73.0	77.0
Sum		194.8	171.4	613.7	451.1	1318.5

Q16 DH 2011 % Somatoform/ psychosomatic disorders	Q16 DH 2011 % Eating / Sleeping Disorders	Q16 DH 2011 % Personality Disorders	Q16 DH 2011 % Other
10	14	24	12
36	32	22	34
10.950	4.607	9.019	6.133
8.8395	6.3068	11.6920	8.4850
26.5	25.0	50.0	31.4
109.5	64.5	216.5	73.6

4.7 Staff

The total level of staffing was consistent across all Day Hospitals. 100% of the Respondents (n = 46) employed at least two Psychiatric Nurses, with a mean of 3.23 full time equivalent nurses in each Day Hospital.

Table 7 (a) provides full details of the Day Hospital staffing with Table 7 (b) providing information on Staffing Hours.

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Table 7 (a): Day Hospital Staffing

		Q13 No. DH Psychiatrists	Q13 No. DH Psych Nurses	Q13 No. DH Psychologists	Q13 No. DH OTs
N	Valid	39	46	28	30
	Missing	7	0	18	16
Mean		1.8308	3.2304	.9696	.9167
Std. Deviation		1.07658	1.75320	.30348	.30635
Range		5.00	7.00	1.75	1.80

Q13 No. DH Psychotherapists	Q13 No. DH Social Workers	Q13 No. DH S&LTs	Q13 No. Administration (Management)	Q13 No. Secretarial	Q13 No. DH Other
9	34	2	13	32	21
37	12	44	33	14	25
1.1111	.9735	.5000	.9231	1.2434	1.4690
.33333	.39929	.70711	.44936	.54322	1.23354
1.00	1.75	1.00	2.00	2.50	5.70

Table 7 (b): Day Hospital Staffing Hours

		Q13 Hrs. DH Psychiatrists	Q13 Hrs DH Psychiatric Nurses	Q13 No. DH Psychologists	Q13 Hrs. DH OTs	Q13 Hrs. DH Psychotherapists
N	Valid	24	37	19	21	7
	Missing	22	9	27	25	39
Mean		22.4167	34.6100	21.8684	17.9762	20.0000
Std. Deviation		14.47537	8.45370	13.51012	13.23039	15.88238
Range		43.50	36.50	36.50	37.00	35.50

Table 7 (b): Day Hospital Staffing Hours (Continued)

Q13 Hrs. DH Social Workers	Q13 Hrs. DH S&LTs	Q13 Hrs. Administration (Management)	Q13 Hrs. Secretarial	Q13 Hrs Other
20	0	6	22	10
26	46	40	24	36
21.1250		25.4583	26.9432	19.4500
12.66873		8.48884	11.66393	12.51765
36.50		18.50	35.50	37.00

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4.8 Origination of Referrals to Day Hospitals 2011

Respondents were asked who had referred Service Users to the Day Hospital in 2011. Table 8 below outlines the responses.

Table 8: Who Referred Service Users to Day Hospital in 2011

Who Referred Service Users to Day Hospital in 2011	n/DHs	% Mean (s.d)
Psychiatric Hospital/Acute Psych Unit (Approved Centre)	28	20.08 (16.753)
Community Mental Health Services	28	37.78 (33.747)
Outpatient Service	22	36.42 (24.027)
Psychiatrist / Neurologist in Private Practice	4	38.00 (44.44)
Psychotherapist in Private Practice	-	-
General Practitioner	20	71.50 (29.895)
Patient Herself/Himself	6	4.5 (2.34)
Other	7	7.50 6.10)

4.9 Treatment Activities

Twenty Six Therapeutic Activities provided in the Day Hospitals were reported as follows:

Table 9 : Therapeutic Activities provided in Day Hospitals (n = 46)

Education in coping with Symptoms	100%	Education in Handing Medication	100%
Psychiatric Nursing Activities	100%	Therapeutic Talks	93.5%
Assessing Social Problems	95.7%	Interventions during Psychiatric Crisis	95.7%
Promoting Contacts	89.1%	Assistance in Coping with Day Structure	89.1%
Direct Day Structuring	84.8%	Counselling for Social Problems	89.1%
Counselling for Lifestyle	89.1%	Outreach Activities (e.g. home visits)	89.1%
Planning of Leisure Activities	84.8%	Psychological Interventions	84.8%
Individual Psychotherapy	82.6%	Social Skills Training	71.7%
Biological-psychiatric interventions	69.6%	Activation	69.6%
Occupational Therapy	58.7%	Training in everyday living (Cooking etc)	54.3%
Vocational Therapy	37%	Sporting Activities	23.9%
Music Therapy	17.4%	Dance Therapy	6.5%
Physiotherapy	4.3%	T. A. Categorised as Other	41.3%

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4.10 2010 & 2011 Attendances

Tables 10.1, 10.2, 10.3, 10.4 & 10.5 provide information on the Day Hospital attendances during 2010 and 2011.

Table 10.1: 2010 Day Hospital New Attendees

		Value
Standard Attributes	Label	Q15 New Attendees 2010
N	**Valid**	**40**
	Missing	6
Central Tendency and Dispersion	**Mean**	**201.15**
	Standard Deviation	471.717
	Percentile 25	49.50
	Percentile 50	100.50
	Percentile 75	221.00

Table 10.2: 2010 Total Day Hospital Attendances

		Value
Standard Attributes	Label	Q15 Total Attendances 2010
N	**Valid**	**39**
	Missing	7
Central Tendency and Dispersion	**Mean**	**2746.82**
	Standard Deviation	1990.023
	Percentile 25	1627.00
	Percentile 50	2238.00
	Percentile 75	3801.00

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Table 10.3: 2011 Day Hospital New Attendees

		Value
Standard Attributes	Label	Q15 New Attendees 2011
N	**Valid**	**39**
	Missing	7
Central Tendency and Dispersion	**Mean**	**221.59**
	Standard Deviation	502.221
	Percentile 25	43.00
	Percentile 50	113.00
	Percentile 75	224.00

Table 10.4: 2011 Total Day Hospital Attendances

		Value
Standard Attributes	Label	Q15 Total Attendances 2011
N	**Valid**	**40**
	Missing	6
Central Tendency and Dispersion	**Mean**	**2645.81**
	Standard Deviation	2092.841
	Percentile 25	1498.50
	Percentile 50	2387.50
	Percentile 75	3396.50

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Table 10.5 Average Daily Attendance Day Hospital

		Value
Standard Attributes	Label	Q15 Average Daily Attendance
N	**Valid**	**39**
	Missing	7
Central Tendency and Dispersion	**Mean**	**17.10**
	Standard Deviation	15.767
	Percentile 25	9.00
	Percentile 50	12.00
	Percentile 75	16.00

4.11 Communication - Approved Centres & Primary Care Network

4.11.1 Level of Communication between Day Hospital and Approved Centres

21.7% of Day Hospitals rated communication with the Approved Centres in their area as 'Excellent', 37% rated it as 'Very Good', 19.6% Good, 13% Satisfactory and 6.5% Poor.

4.11.2 Level of Communication between Day Hospital and Primary Care Network in DH Area

13% of Day Hospitals rated communication with the Primary Care Network in their area as 'Excellent', 23.9% rated it as 'Very Good', 17.4% Good, 28.3% rated it as Satisfactory with 13% rating it as 'Poor'.

56.5% of Respondents did not see an overlap between the work of the Day Hospital and the work of the Primary Care Network. 13% indicated some overlap e.g (i) Primary Care Centre has Psychiatric Outpatient Department, (ii) Personal Care attended to in Day Hospital may overlap with work in Primary Care, (iii) overlap in terms of accessing Home Care Grants.

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Respondents reported a Mean of 2.17 Primary Care Teams in their local catchment areas (s.d. 1.636).

Asked their views on whether Primary Care Teams complement the work of the Day Hospital 50% (n = 23) said 'Yes' and 30.4% (n = 14) said 'No' with the remaining Day Hospitals (n = 9) not indicating either yes or no.

4.12 Mental Health Policy / Service Provision Ethos

4.12.1 Advocacy & Day Hospital Service Provision

Day Hospitals were asked to outline how Service Users attending the Day Hospital access Advocacy Services.

34.8% (n = 16) of Day Hospitals responded that information on advocacy is available and there are visits from the Advocacy Officer to the Day Hospital, a further 28.3% (n = 13) indicated that information about the Regional Advocate including their contact number was made available to Service Users. 6.5% (n = 3) responded by indicating 'Self / Staff Referral, with a further 6.5% naming the National Advocacy provider i.e Irish Advocacy Network. Other responses included: (i) Information available and staff encourage use of Advocacy Services, (ii) Education sessions are held with CMHT and Social Workers, (iii) Advocacy available in local catchment area however, no direct provision in Day Hospital due to lack of resources, (iv) Monthly meetings held in the past, however, no Advocate at present and (v) monthly service user group forum which provides feedback and an opportunity for Service Users to discuss issues of interest.

Chapter 4 (Part D) details feedback from Peer Advocates on Community Mental Health Services and in particular, their work in Day Hospitals and Day Centres also.

4.12.2 Involvement of Service Users in Designing and Developing Services

Respondents were asked 'How are Service Users involved in designing and developing services?'. 19.6% (n = 9) responded that a 'consultation process is in place with Service Users of the Day Hospital' to ensure their involvement. 6.5% (n = 3) confirmed that direct feedback from service users is sought and feedback from the Advocacy representative also.

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A further 6.5% used the HSE's 'Your Service – Your Say' questionnaire to ascertain Service Users views. 4.3% indicated that Service Users attend Sector meetings. 8.6.% indicated that any ideas from Service Users are taken on board regularly and utilised in developing meaningful activities. For the remaining 58% of Day Hospitals there were a variety of responses which are detailed in Table 11 below.

Table 11: Are SUs involved in Design and Developent of Service

	Frequency	Percent	Valid Percent	Cumulative Percent
Service Users attend Sector meetings	2	4.3	4.4	4.4
Any ideas from Service Users are taken on board, utilised in developing meaningful activities	2	4.3	4.4	8.9
Views sought regularly / opinions & ideas	2	4.3	4.4	13.3
Meetings held every 3 months - suggestion box available - user satisfaction survey	1	2.2	2.2	15.6
Numerous committees with SU involvement SU rep on each committee	1	2.2	2.2	17.8
Process of developing a Service User Satisfaction Questionnaire measure against standards in QFMHS / Plan to implement Performance improvement initiatives	1	2.2	2.2	20.0
Views Qn on discharge, evaluation, verbal enquiry, formal complaints procedure , audit of activity	1	2.2	2.2	22.2
Not really involved in design and dev of services	1	2.2	2.2	24.4
Consultation process in place with Service Users	9	19.6	20.0	44.4
Advocacy rep attends business meetings / included in development/design discussions	2	4.3	4.4	48.9
direct feedback from SU, Advocacy representative	3	6.5	6.7	55.6
SUs were part of planning structure & meetings now top down approach	1	2.2	2.2	57.8
Through involvement in Care Planning	1	2.2	2.2	60.0
Survey carried out with SUs to assist service development followed by evaluation process. Continuous review	1	2.2	2.2	62.2
SUs on consumer panel, clinical governance, link up forum, icps, steering groups	1	2.2	2.2	64.4
Sector has active user group with Rep on Sector Management Team	1	2.2	2.2	66.7
Carers Group / Suggestion box	2	4.3	4.4	71.1
Psycho education programmes / Suggestion box	1	2.2	2.2	73.3
Users views Questionnaire being developed	1	2.2	2.2	75.6

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Through use of surveys and satisfaction questionnaires	1	2.2	2.2	77.8
Attending advocacy meetings / use of questionnaires	1	2.2	2.2	80.0
ICP, Advocacy Services, Partnership groups, co-operative leadership course DCU	1	2.2	2.2	82.2
Service User forum attached to local Approved Centre	1	2.2	2.2	84.4

4.12.3 Individual Care & Treatment Plans for Day Hospital Service Users

80.4% (n = 37) of Day Hospitals responded 'Yes' to the question 'Do all Service Users of the Day Hospital have an Individual Care and Treatment Plan developed?'. 17.4% (n = 8) indicated that all Service Users 'Do Not' have an ICP. One Day Hospital (2.2%) responded that ICPs were currently being developed for introduction to the service.

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4.13 RESULTS - PART B - DAY CENTRE SERVICE PROVISION

The principal focus of day centres is to provide social support for individuals who have chronic and enduring mental health presentations and to support rehabilitation, social inclusion and recovery. The following represents the findings of a study in which 27 Day Centres participated nationally. The survey instrument used was a 26-question questionnaire for the assessment of both structural and procedural variables and measures of Mental Health Day Centres (available at Appendix 5)

4.13.1 Sample Characteristics

Respondents indicated that the profile of the local catchment areas serviced by the Day Centres were: 29.6% Combination of Urban, Suburban and Rural, 29.6% Urban, 25.9% Rural, 11.1% Suburban, 3.7% City.

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4.13.1.1 Location of Day Centre

59.3% of Day Centres were located more than 15 minutes from an Approved Centre (Psychiatric Hospital or Acute unit within a General Hospital) with a range of between 20 and 60 minutes travel time. 14.8% were located on the hospital grounds, 11.1% within 15 minutes from the hospital grounds by public transport, with 7.4% located next to the hospital grounds and 7.4% inside the hospital building.

4.13.2 Organisation & Structure

48.1% (n = 13) of Day Centres reported that they had a fixed number of places available with a mean of 25.69 (s.d. = 11.757) places.

Day Centres offer a service from Mondays to Fridays with 96.3% (n = 26) indicating that no weekend service was available, only one centre indicated that they did provide a weekend service. 66.7% (n = 18) of Day Centres indicated that 'Service Users attend the Day Centre depending on their individual needs'. With 25.9% (n = 7) indicating both options i.e. that service users attended both Monday to Friday and depending on their own needs and 7.4% (n = 2) of respondents indicated that attendance was Monday to Friday.

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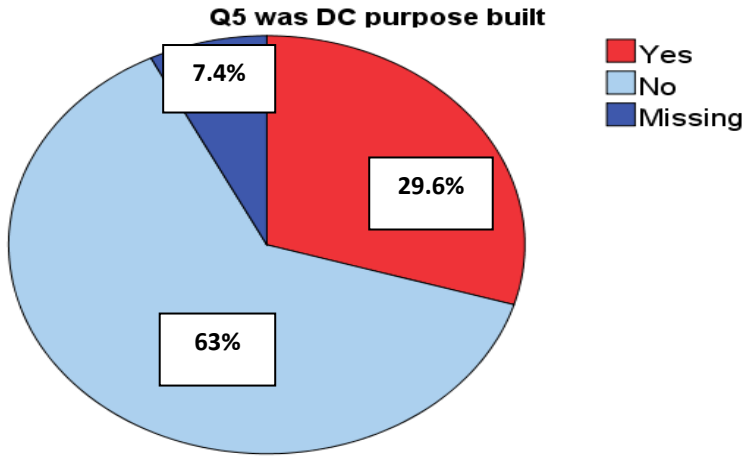
With regards to average daily hours of attendance, 66.7% (n = 18) of respondents indicated a minimum of 6 hours, with a further 22.2% (n = 6) indicating 4 hours as the average daily attendance.

55.6% (n = 15) of Day Centres were open from 9:00am to 5:00pm, 11.15% (n = 3) opened from 8.30am to 4.40pm, 11.1% 9:00am to 4.30pm with the remaining times being 3.7% (n = 1) opened 10:00 am to 4:00pm, 3.7% (n = 1) 9:00am to 4:00pm and one day centre (3.7%) opened one day per week 11:00am to 3:00pm.

85.2% (n = 23) of Day Centres provided a daily meal to service users. Leaving 14.8% (n = 4) not providing such a service.

Figure No: 2 % of Day Centres that were Purpose Built



63% (n = 17) of Day Centres were established in existing premises, with 29.6% (n = 8) purpose built.

85.2% (n = 23) of Day Centres provided the year that their Day Service commenced. The longest established service commenced in 1975, with the most recent established in 2010.

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Table 12: Year Day Centre Services Commenced

DC YR Service commenced		Frequency	Percent
Valid	1975	1	3.7
	1984	1	3.7
	1985	3	11.1
	1986	1	3.7
	1987	3	11.1
	1992	2	7.4
	1993	1	3.7
	1994	1	3.7
	1996	2	7.4
	1998	1	3.7
	1999	1	3.7
	2000	1	3.7
	2001	1	3.7
	2002	1	3.7
	2003	1	3.7
	2006	1	3.7
	2010	1	3.7
	Total	23	85.2
Missing	System	4	14.8
Total		27	100.0

4.13.2.1 Day Centre Premises

Respondents were asked to provide a brief description of their Day Centre premises, these varied considerably. 76% (n = 35) provided the information. To give the reader an insight these are detailed below in Table 13

Table No 13: Description of Day Centre Premises

Description of Day Centre Premises	**No**
Situated in grounds of Community Hospital	3

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Old Lodge Type Building (1842) adjacent to Gen Hos. Two story building, 15 rooms/areas. Extensively renovated in 1980s	1
Former hospital ward, two former dormitories, side rooms, kitchen, toilets	1
Two storey detached building consisting of 10 - 20 rooms	2
Health Care Unit - premises rate along best in the country	1
Single storey building situated within walking distance town and sector HQ	1
Single story L shaped building attached to Primary Care Centre	1
Separate building from Community Hospital, prefab type added 2007 number of rooms	1
New purpose built wing at Community Hospital	1
DC Premises in Industrial / Commercial Estate	2
Bunaglow style building with office, interview rooms, 2 GT Rooms, Waiting rooms and Kitchen	1
Large Victorian 2 storey building, currently opd clinic and day centre	1
1 DC in large manor house extensive grounds + 1 in large terraced house town centre	1
DC incorporated into purpose build community health care unit	1
Purpose built as Geriatric DC in 1980, used by MH service since 2002.	1
Siutated 1st floor of hospital complex	1
Leased community based parish centre (leased 1 day per week)	1
Total	21
Did not provide description.	6
Total:	27

4.13.2.2 Adequacy of Day Centre Premises to Meeting Service Needs

Day Centres were asked to rate if their premises were adequate to meet Service Needs on a Likert Scale of 1 to 5, with 1 representing 'Not Adequate' and 5 representing 'Meets Service Needs Well'.

59.3% (n =16) of Day Centres indicated that their Day Centre premises 'Meets their Service Needs', 22.2 (n = 6) responded that their Premises 'Meets their Needs Well', 14.8% (n = 4) considered their premises to be 'Adequate for Service Needs' with one Day Centre 3.7% indicating that their premises was 'Not Adequate' to meet Service Needs.

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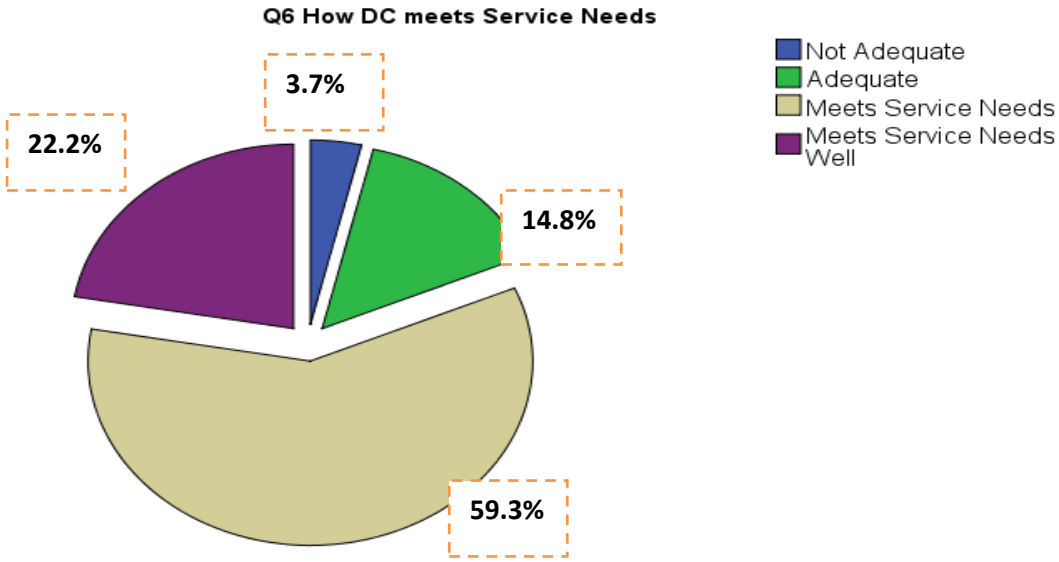
Figure 3: How Day Centre Premises Meets Service Needs



4.13.3 Aims & Functions of Day Centres

Respondents were asked to list the main aims and functions of the Day Centre and rate on a Likert Scale of 1 – 5, with 1 representing no importance and 5 representing greatest importance. Unlike the Day Hospital questionnaire a list of 'Aims & Functions' was not included, therefore, there were a wide variety of responses. These were then sub-divided into the main themes to aid review. For information the full listing is available at Appendix 8. On review, not providing a 'suggested list of aims and functions' was not the best approach. What respondents provided, was mainly a list of the therapeutic interventions which are provided, rather than the specific Day Centres aims and functions which distinguish it for the role of the Day Hopsital. Indeed, this may have been the more appropriate and fruitful question to ask.

Nothwithstanding the above shortcomings now acknowledged by the Researcher to this question, the 24 sub-divided themes are outlined in Table 14.

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Table: 14: Sub-divided Themes – Aims & Functions of Day Centres

• Promote Recovery & Independence	• Provide an environment for service users to feel safe, supported and understood
• Medication management, monitoring therapies and care needs	• Socialisation
• Activation	• Monitoring Mental State
• Assessment and Care Planning	• Crisis Planning
• Daily Living Skills	• Engagement in Community
• Interface with General Practitioners	• Peer Support Social Integration
• Early Intervention, identification of Relapse	• Individual Safety Needs
• Liaise with MDT Members	• Psychotherapy
• Relapse Prevention	• Anxiety Management
• Preparation for Work Training	• Support for families
• Problem Solving / Symptom Reduction	• Art therapy, reflexology, solutions for wellness
• Money Management Skills	• Mental Health Education

51% (n = 14) rated the 'Promotion of Recovery & Independence' as an aim or function of the Day Centre with great or greatest importance. 44% (n = 12) rated 'Monitoring Mental State' as either of great or greatest importance with 40% (n = 11) rating 'Medication management, monitoring therapies and care needs' as either of great of greatest importance. 40% (n = 11) also rated Assistance with Daily Living Skills as great or greatest importance.

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4.13.4 Patient Exclusion Criteria

55.6% (n = 15) of Day Centres indicated that they did have Exclusion Criteria, with 44.4% (n = 12) responding that there was no Exclusion Criteria.

The categories of Exclusion Criteria were: 22% (n = 6) EC pertained to Risk to Staff by SUs / Forensic, 14.8% (n = 4) Person under influence of alcohol or drugs or those causing repeated disruption. 7% (n = 2) Service Users with acute mental health difficulties who require inpatient care, 3.7% (n = 1) Service User must have reasonable prospect of benefitting from programme, 3.7% (n = 1) no wheelchair access to Day Centre.

4.13.5 Characteristics of Patients

During 2011, the majority of Day Centres provided a service for service users with a diagnosis of Schizophrenia. Table 15 below provides further details.

Table 15 : Day Centres - Main Diagnosis of Service Users in 2011

		Q15 DC 2011 % Organic Disorders	Q15 DC 2011 % Addiction/ Abuse	Q15 DC 2011 & Schizophrenia	Q15 DC 2011 % Schizo-affective disorders
N	Valid	7	15	22	16
	Missing	20	12	5	11
Mean		9.857	5.567	**46.027**	16.156
Std. Deviation		17.9018	4.1095	25.8680	15.0152
Range		50.0	15.0	95.0	50.0

Q15 DC 2011 % Affective Disorders	Q15 DC 2011 % Somatoform/psychosomatic disorders	Q15 DC 2011 % Eating / Sleeping Disorders	Q15 DC 2011 % Personality Disorders	Q15 DC 2011 % Other
16	7	3	11	12
11	20	24	16	15
25.563	8.571	1.667	4.955	10.500
15.7012	8.4035	2.0817	3.3351	10.3199
62.0	20.0	4.0	10.0	30.0

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4.13.6 Staff

96.3% (n = 26) of the Day Centres employed at least two Psychiatric Nurses, with a mean of 2.17 full time equivalent nurses in each Day Centre. Table 16 below provides full details of the Day Centre staffing with Table 17 providing information on Staffing Hours.

Table 16: Day Centre Staffing

		Q12 No. DC Psych Nurses	Q12 No. DC Psychologists	Q12 No. DC OTs	Q12 No. DC Psychotherapists
N	Valid	26	6	7	5
	Missing	1	21	20	22
Mean		2.1731	.9167	.9286	2.2000
Std. Deviation		.96894	.20412	.18898	2.16795
Range		3.00	.50	.50	5.00

Q12 No. DC Social Workers	Q12 No. DC S&LTs	Q12 No. Administration (Management)	Q12 No. Secretarial	Q12 No. DC Other
9	0	1	5	18
18	27	26	22	9
1.0000		.5000	.9000	1.9167
.00000			.22361	2.14373
.00		.00	.50	9.50

Table 17: Day Centre Staffing - Hours

		Q12 Hrs DC Psychiatric Nurses	Q12 No. DC Psychologists	Q12 Hrs. DC OTs	Q12 Hrs. DC Psychotherapists
N	Valid	26	5	5	4
	Missing	1	22	22	23
Mean		34.4104	7.7000	12.8000	15.2500
Std. Deviation		7.35086	6.97854	15.51451	16.78044
Range		32.00	18.00	37.00	37.00

Q12 Hrs. DC Social Workers	Q12 Hrs. DC S&LTs	Q12 Hrs. Administration (Management)	Q12 Hrs. Secretarial	Q12 Hrs Other
6	0	1	4	18
21	27	26	23	9
17.5833		26.0000	23.5000	30.2778
17.35055			17.89786	14.55034
38.00		.00	31.00	57.00

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4.13.7 Origination of Referrals to Day Hospitals 2011

Respondents were asked who had referred Service Users to the Day Centre in 2011. Table 18 below outlines the responses.

Table: 18 - Who Referred Service Users to Day Centre in 2011

Who Referred Service Users to Day Centre in 2011	n/DCs	% Mean (s.d)
Psychiatric Hospital/Acute Psych Unit (Approved Centre)	15/27	31.93 (28.26)
Community Mental Health Services	22/27	57.59 (35.50)
Outpatient Service	14/27	28.36 (28.38)
Psychiatrist / Neurologist in Private Practice	--	-
Psychotherapist in Private Practice	2/27	50 (70.71)
General Practitioner	6/27	11 (11.4)
Patient Herself/Himself	2/27	38 (46.17)
Other	5/27	7.50 (6.10)

4.13.8 Treatment Activities

Twenty Three Therapeutic Activities provided in the Day Centres were reported as follows, with the top eleven highlighted below

Table 19: Therapeutic Activities provided in Day Centres (n = 27)

Activation	96.3%	Direct Day Structuring	92.6%
Promoting Contacts	92.6%	Education in Coping with Symptoms	96.3%
Coping with Simple Day Structure	92.6%	Planning of Leisure Activities	92.6%
Social Skills Training	88.9%	Training in Everyday Living (cooking etc)	88.9%
Interventions during Psychiatric Crisis	88.9%	Counselling for Social Problems	88.9%
Education in Medication Handling	88.9%	Therapeutic Talks	85.2%
Counselling for Lifestyle	81.5%	Assessing Social Problems	77.8%
Sporting Activities	66.7%	Music Therapy	63%
Psychological Interventions	51.9%	Vocational Therapy	44.4%
Individual Psychotherapy	37%	Occupational Therapy	37%
Dance Therapy	25.9%	Physiotherapy	18.5%
T.A categorised as ‘Other’	51.9%		

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4.13.9 2010 & 2011 Attendances

Table 20: Information on Day Centre attendances for 2010 and 2011.

		Q14 New Attendees 2010	Q14 Total Attendances 2010	Q14 New Attendees 2011	Q14 Total Attendances 2011	Q14 Average Daily Attendance
N	Valid	21	18	21	20	22
	Missing	6	9	6	7	5
Mean		10.95	3398.67	147.81	3265.80	21.77
Std. Deviation		11.057	2929.991	634.344	2814.854	12.027
Range		45	13417	2915	12383	48

4.13.10 Communication

5.10.1 Level of Communication between Day Centres and Day Hospital

74% (n = 20) of Day Centres responded to this question and rated their level of Communication with the Day Hospitals in their area on a Likert scale of 1 to 5 with 1 representing 'poor communication' and 5 representing 'excellent communication'. 25.9% of Day Centres rated the communication levels with the Day Hospitals in their area as 'Excellent', 29.6% rated it as 'Very Good' with a further 11.1% giving a rating of 'Good'. The other ratings provided were 3.7% indicating that Communication was Satisfactory and 3.7% rating it as 'Poor'.

4.13.10.2 Level of Communication between Day Centre and Approved Centres in DC Area

92.5% (n = 25) of Day Centres responded to this question and rated their level of Communication with the Approved Centres in their area on a Likert scale of 1 to 5. 29.6% of Day Centres rated the level of Communication with Approved Centres in their area as 'Excellent', a further 29.6% rated it as 'Very Good' and 22.2% gave a rating of 'Good'. As with the Day Hospital Communication much smaller percentages gave rates of Satisfactory at 7.4% and Poor at 3.7%

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4.13.10.3 Level of Communication between Day Centre and Primary Care Network in DC Area.

All the Day Centres (n = 27) responded to this question with 44.4% indicating that communication with the primary care network in their area was 'Very Good', 14.8% rated it as 'Excellent' and 25.9% gave a 'Good' rating. The remaining 14.8% considered communication to be at a ''Satisfactory' level.

51.9% (n = 14) of Day Centres indicated that there was one primary care team in their local catchment area, with 11.1% indicating two teams and 7.4% three teams.

4.13.11 Mental Health Policy / Service Provision Ethos

4.13.11.1 Advocacy & Day Centre Service Provision

Day Centres were asked to outline how Service Users attending the Day Centre access Advocacy Services.

33.3% (n = 9) of Day Centres responded that information on Advocacy for example, contact information is provided to Service Users. 22.2% (n = 6) reported that an Advocate attends the Day Centre on a regular basis and is also available on request. Other responses included: (i) Poster/booklets available with patient advocate meeting once or twice a year, (ii) no advocacy service available in the last few months, as no advocate available to visit, (iii) Service Users contact the Advocacy service directly or by Staff Referral, (iv) Regional Advocate visits also voluntary organisation facilities client focus groups, (v) advocate visits on six weekly basis, support meeting advertised on DC notice board, (vi) Day Centre has two service user representatives, (vii) Self Referral and (viii) provision of advocacy information paramount in Day Centre, regular information sessions and National Advocacy Service has visited.

As mentioned earlier Chapter 4 Part D details feedback from Peer Advocates on Community Mental Health Services and in particular, their work in Day Hospitals and Day Centres also.

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4.13.11.2 Involvement of Service Users in Designing and Developing Services

Respondents were asked to outline 'How are Service Users involved in designing and Day Centre developing services?'.

44.4% (n = 12) responded that there are regular consultation meetings with Service Users of the Day Centre and opportunities for feedback. 11.1% (n = 3) indicated that that input of service users is sought for the development of new programmes and activities, with a further 11.1% (n = 3) indicating that there is a Service User Committee/Association established for this purpose. Other responses included: (i) Service User Survey undertaken every two years to obtain feedback on programmes and design, (ii) Day Centres are run as Clubs with Committee of Service Users elected annually to manage and direct service provision, (iii) Service Users are encouraged to voice their needs and preferences also encouraged to participate in national service user survey. (iv) Service User focus groups provide recognised forum for expectations to be aligned to service delivery, monthly meetings take place. (v) Individual Care planning, multidisciplinary approach to care, also comments, suggestions, satisfaction survey. (vi) process currently being developed on how this can happen, (vii) community meetings take place and (viii) Day Centre staff with Advocacy Representative hold sessions to gain the opinions of Service Users.

4.13.11.3 Permeation of Recovery Approach in Day Centre Service Provision

Table 21 overleaf outlines how Day Centres demonstrated the permeation of a Recovery Approach in their Services.

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Table 21: Permeation of Recovery in Day Centre Service

Q24 Permeation of Recovery in Day Centre

		Frequency	Percent	Valid Percent	Cumulative Percent
	Recovery Approach part of Day Centre philosophy	12	44.4	48.0	48.0
	Endeavour to make Recovery central to Service delivery, however, resource constraints impacting, left prioritising 'must do'	3	11.1	12.0	60.0
	Anxiety Management Programme being introduced. Precursor to developing Day Hospital model of care. Referrals will come via MDTs then	1	3.7	4.0	64.0
	Very much a focus in the past year within service, education on an ongoing basis	1	3.7	4.0	68.0
	Service has developed user led programme models. Service delivery has changed from Day Centre to a more collaborative club model	1	3.7	4.0	72.0
	Multid ICP, DC programme promotes independence, plans to implement Recovery Star programme with clients	1	3.7	4.0	76.0
	Constantly looking for opportunities to progress recovery agenda	2	7.4	8.0	84.0
	Effort to reduce stigma, Education, Empowering of SUs	2	7.4	8.0	92.0
	Service Users supported in functioning at optimum level, explore lifestyle options available	1	3.7	4.0	96.0
	CMHT established and referral process in place, team approach tailored to Service User Needs, Recovery focused	1	3.7	4.0	100.0
	Total	25	92.6	100.0	
Missing	System	2	7.4		
Total		27	100.0		

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4.14 RESULTS - PART C 24 HOUR STAFFED (HIGH SUPPORT) COMMUNITY RESIDENCES

In-line with the closure of many psychiatric hospitals in Ireland, community residences were established to provide housing to people who had previously lived in hospitals. Those who moved to community residences were people who were previously discharged from long-stay wards. High, medium and low support hostels in Ireland account for over 3,000 residential places.

The following represents the findings of a study undertaken with 30 - 24HR Staffed Community Residences. The survey instrument used was a 'Facility Questionnaire' used in a study undertaken in Ireland and published in 2007 on community residential mental health services (34). As outlined in Chapter 3 the instrument was adapted to include additional questions to elicit the views of respondents on mental health policy in Ireland. The survey instrument included questions pertaining to: (i) Rules & Regulations, (ii) Meals, (iii) Staff, (iv) Admission Procedures, (v) Evaluation Process and Procedures, (vi) Resident Characteristics, (vii) Community Integration and (viii) views on Mental Health Policy.

Organisation / Structure

4.14.1 Description Building/Premises 24 HR Staffed Community Residences

Almost half of the 24 HR Residences were situated in urban areas (43.3%; n = 13) or on their periphery (36.7%; n = 11), with 20% (n = 6) located in a rural areas.
The majority of buildings/premises were owned by the HSE 76.7% (n = 23) with 13.3% being privately owned (n = 4) and 10% (n = 3) owned by the voluntary sector.

70% (n = 21) of the residences were categorised as 'Private Building on Own', with 20% (n = 6) categorised at 'Other' details of which were (a) on the grounds of HSE central office and a community nursing unit, (b) located beside hospital which is a facility for care of the elderly, (c) stand alone building in district hospital grounds, (d) residence adjacent to other units Day Centre, Community Care, Alzheimers unit and (e) on the same grounds as community hospital. 3.3% (n = 1) residence was situated in a housing estate and 6.7% (n = 2) were located on the grounds of a psychiatric hospital.

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4.14.1.1 Internal physical environment and access to local amenities

Table 22: Mean Number of Bedrooms in residences, standard deviation & Range

24HR Community Residences	Mean	SD	Range
Single Bedrooms	5.47	4.703	16
Double Bedrooms	2.87	2.909	13
Triple	0.70	1.393	5
Others	0.07	0.371	2

In contrast to the study published in 2007, there were more single than double bedrooms in the 24 HR High Support Residences that participated in the study, this is a welcome development.

There was a Mean of 5.00 (std. 3.434, r. 13) bathrooms for residents use in the community residences with a Mean of 4.33 (std 2.963, r 12) of bathrooms for 'residents use only'.

There was a Mean of 1.90 (std. 0.712) living rooms in the residences.

Two thirds 66.7% (n = 20) of the 24 HR Residences reported that the building was not suitable for those with mobility problems. Stairs in the building without access to a lift was the main barrier reported at 30% (n = 9).

With the high usage of mobile phones it is not surprising that over half of the residences did not have a public phone 53.3% (n = 16), leaving 46.7% (n = 14) where a public phone was available for residents.

Access to a smoking room was reported as provided by 83.3% (n = 25) of the residences, with 53.3% (n = 16) of these provided 'outside' and 30% provided in the residence (n = 9).

4.14.1.2 Access to local amenities and services

Table 23: Distance to local amenities and services

24HR Community Residences	Mean	SD
Time in minutes to reach shopping centre or general shop on foot	11.40	15.02
Time in minutes to reach shopping centre or general shop by public transport	5.95	13.677
Time in minutes to reach post office on foot	18.53	21.527

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Time in minutes to post office by public transport	5.30	10.19
Time in minutes to reach pub on foot	13.13	19.58
Time in minutes to reach primary care centre GP on foot	20.93	24.50
Time in minutes to reach primary care centre GP on foot	6.43	13.006

Staff in the 24 HR Residences also reported that it took a mean length of time of 9.87 minutes (S.D. 13.513) to get to the Day Hospital by minibus or public transport and a mean length of time of 8.83 minutes (S.D. 12.231) to get to the Day Centre by minibus or public transport.

Few residents had access to their own transport, 6.6% (n =2) had a car and 10% (n = 3) had a bicycle. No residents owned a motorbike. Therefore, 83.3% (n = 25) did not have their own transport.

73.3% (n = 22) of residences had a minibus. 20% (n = 6) shared their minibus with another facility.

4.14.2 How does the Community Residence Premises Meet the Service Delivery Needs?

Staff in the 24HR Community Residences were asked to rate if their premises were adequate to meet Service Needs on a Likert Scale of 1 to 5, with 1 representing 'Not Adequate' and 5 representing 'Meets Service Needs Well'.

36.7% (n = 11) of 24 HR Community Residences indicated that their premises 'Meets their Service Needs', 30% (n = 9) rated their premises as 'Adequate for Service Needs' with 26.7% (n = 8) responding that their Premises 'Meets their Needs Well', the remaining 6.7% (n = 2) considered their premises to be 'Reasonably Adequate for Service Needs'. No service gave a rating of '1' i.e. 'Not Adequate' on the scale .

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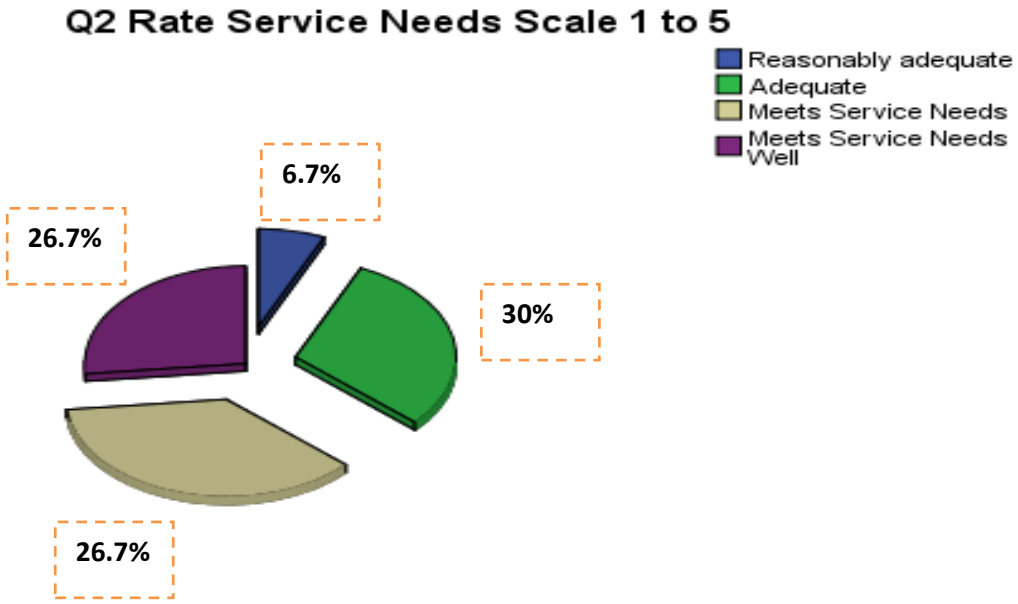
Figure 4: How 24 HR Residence Premises Meets Service Needs



4.14.3 Policy / System for Living in the Residence

Respondents were asked a number of questions focused on Rules and Regulations within the Residence. Tables 24 (a) through to 24 (k) provides the response data.

Table 24(a): Do Residence Staff Supervise Daytime Comings & Goings

Q4staffsuper

		Value	Count	Percent
Standard Attributes	Label	Q4 Do res staff supervise daytime comings and goings		
	Type	Numeric		
N	Valid	30		
	Missing	0		
Labeled Values	1	**Yes**	**28**	**93.3%**
	2	No	2	6.7%

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Table 24 (b): Are Residents Allowed to Leave the Unit unsupervised?

Q4leaveunsuper

		Value	Count	Percent
Standard Attributes	Label	Q4 Are residents allowed to leave the unit unsupervised		
	Type	Numeric		
N	Valid	30		
	Missing	0		
Labeled Values	1	**Yes**	**26**	**86.7%**
	2	No	3	10.0%
	3	Some residents are	1	3.3%

Table 24 (c): Do Residents have a Front Door Key?

Q4frontdoorkey

		Value	Count	Percent
Standard Attributes	Label	Q4 Do residents have a front door key		
	Type	Numeric		
N	Valid	30		
	Missing	0		
Labeled Values	1	Yes	2	6.7%
	2	**No**	**28**	**93.3%**

Table 24 (d) : Can residents lock Bathroom Doors?

Q4lockbathroom

		Value	Count	Percent
Standard Attributes	Label	Q4 Can residents lock bathroom facilities		
	Type	Numeric		
N	Valid	30		
	Missing	0		
Labeled Values	**1**	**Yes**	**26**	**86.7%**
	2	No	4	13.3%

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Table 24 (e) : Are Visiting Hours to the Residence Scheduled?

Q4Visithours

		Value	Count	Percent
Standard Attributes	Label	Q4 Are Visiting hours scheduled		
	Type	Numeric		
N	Valid	30		
	Missing	0		
Labeled Values	1	Yes	4	13.3%
	2	**No**	**26**	**86.7%**

Table 24 (f) : Are Residents required to go to bed at a given time?

Q4timeBed

		Value	Count	Percent
Standard Attributes	Label	Q4 Are residents required to go to bed at given time		
	Type	Numeric		
N	Valid	30		
	Missing	0		
Labeled Values	1	Yes	5	16.7%
	2	**No**	**25**	**83.3%**

Table 24 (g): Do staff make sure Residents are in bed?

Q4checkbed

		Value	Count	Percent
Standard Attributes	Label	Q4 Do staff run check to make sure residents in bed		
	Type	Numeric		
N	Valid	30		
	Missing	0		
Labeled Values	1	**Yes**	**30**	**100.0%**
	2	No	0	0.0%

Table 24 (h) : Are residents required to be up at a given time on weekdays?

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Q4timeupWD

		Value	Count	Percent
Standard Attributes	Label	Q4 Are residents required to be up at a given time weekdays		
	Type	Numeric		
N	Valid	30		
	Missing	0		
Labeled Values	1	**Yes**	**23**	**76.7%**
	2	No	7	23.3%

Table 24 (i) : Are residents required to be up at a given time at weekends?

Q4timeupWE

		Value	Count	Percent
Standard Attributes	Label	Q4 Are residents required to be up at a given time weekends, holidays etc		
	Type	Numeric		
N	Valid	30		
	Missing	0		
Labeled Values	1	Yes	4	13.3%
	2	**No**	**26**	**86.7%**

Table 24 (j) : Are residents required to notify staff where they go?

Q4checkoutnotify

		Value	Count	Percent
Standard Attributes	Label	Q4 Are residents required to notify staff where they go		
	Type	Numeric		
N	Valid	30		
	Missing	0		
Labeled Values	1	**Yes**	**23**	**76.7%**
	2	No	4	13.3%

Table 24 (k) : Are residents required to check in at a given time?

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Q4Checkin

		Value	Count	Percent
Standard Attributes	Label	Q4 Are residents required to check in at a given time		
	Type	Numeric		
N	Valid	30		
	Missing	0		
Labeled Values	1	Yes	11	36.7%
	2	**No**	**16**	**53.3%**

90% (n = 27) of Respondents indicated that Residents could stay in their bedrooms during the day if they wished. However, 80% (n = 24) responded that Residents were not allowed to lock their bedroom doors. 100% (n = 30) responded that Residents were not allowed to smoke in their bedrooms. 50% (n = 15) of respondents also indicated that Residents could not choose who they shared their bedroom with, 30% (n = 9) indicated that Residents could choose and 20% did not respond either way to this question. 56.7% (n = 17) responded that Residents could not choose to stay in single rooms. However, this is most likely due to the number of double and other types of rooms that still exist in the Residences.

93.3% (n = 28) confirmed that there were areas where residents can be left on their own if they so wished.

4.14.3.2 Residents Belongings & Finance

60% (N = 18) confirmed that staff do run a check on Residents belongings. However, 73.3% (n = 22) responded that Residents belongings are not listed. In response to a question on Finances i.e. Can Residents administer their own finances, 73.3% (n = 22) responded that 'Some' residents can administer their own finances, 16.6% (n = 5) responded 'Yes' to this question.

4.14.3.3 Residents Meals

86.7% (n = 26) responded that the food for the Residence was not prepared by the psychiatric hospital/unit. Kitchen staff prepared the food in the majority of residences both

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during the week and at weekends. Table 25 below shows who had responsibility for the preparation of residents' food.

Table 25: Preparation of food in the 24HR Residences Weekdays and Weekends.

Who prepares Meals during the week	**Percent (n)**	**Who prepares Meals at the Weekend**	**Percent (n)**
Residents	0%	Residents	0%
Staff	23.3% (n = 7)	Staff	20% (n = 6)
Residents & Staff	10% (n = 3)	Residents & Staff	20% (n =6)
Kitchen Staff	46.7% (n = 14)	Kitchen Staff	46.7% (n = 14)
Day Centre Main meal Monday to Friday	6.7% (n = 2)	N/A	_____
Residents & Staff & Kitchen Staff	10% (n = 3)	Residents & Staff & Kitchen Staff	3.3% (n = 1)
Residents & Kitchen Staff	3.3% (n = 1)	Residents & Kitchen Staff	3.3% (n = 1)

66.7% (n = 20) indicated that Staff do not have their main meals in the Residence. 93.3% (n = 28) indicated that Residents can choose the menu, with 86.7% (n = 26) also confirming that Residents can follow a diet if they wish.

53.3% (n = 16) responded that Residents do purchase food from the shop. However, 63.3% (n = 19) indicated that Residents do not have unrestricted access to the kitchen in the Residence.

4.14.4 Staffing of Residence

Residents were asked to report on the number of staff , the categories of which were (i) Nurses, (ii) Care Staff, (iii) Household and (iv) Others and also the hours worked in each scheduled shift.

All Residences as 24 HR High Support Hostels had a 24 Hour Working Day.

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In total 97% (n = 29) of the Residences (1 Residence did not provide data on staffing) had a total of 103 nursing staff (mean 3.55). 53% (n = 16) of the Residences reported that they had Care Staff, the total of which for the Residences was 29 (mean 1.81). 76% (n = 23) of Residences reported that they had 'Household Staff' the total of which for the Residences was 28 (mean 1.21). Only 1 residence reported 1 staff member in the 'Other category.
The Hours reported varied considerably and are provided in the tables below.

Table 26: Nurse Hours Worked per 24 HR Residence

Other Nurse Time		Frequency	Percent
Valid	0	4	13.3
	1 Nurse working 12.5 hrs x 2	1	3.3
	2 Nurses working 12 hour days and 2 nurses working 12 hour nights	2	6.7
	1 nurse working 12 hour day and 1 nurse working 12 hr night	5	16.7
	1 Nurse working 12 hour day & 2 Nurses working 12 hour night	1	3.3
	8 nurses each doing 37.5 hours per week	1	3.3
	2 nurses on duty 24 hours	1	3.3
	Day 1 nurse 07:45 to 20.30 / CNM2 9.00 to 17.30 - night 20.00 to 8.00	1	3.3
	2 nurses working 08:00 - 20:00 and 1 nurse working 20:00 to 8:00	4	13.3
	3 nurses working days 07.42 to 20.10 and 2 working nights 20.05 to 07.48	1	3.3
	1 RPN X 12 hrs day + 1 RPN X 12 Hours night + 1 CNMII X 7.5hrs	2	6.7
	1 nurse 12 hours and 1 nurse 10 hours	1	3.3
	3 Nurses each working 12 hr shifts	1	3.3
	2 nurses working 12 hour day and 2 nurses working 12 hour night plus CNM2 working 7.5 hrs	1	3.3
	2 nurses working 13.5 hrs day and 1 nurse working 10.5 hrs night	1	3.3
	2 nurses x 7.5 hrs early, 1 nurse x 7.5 hrs late, 1 nurse x 10.7 hrs night	1	3.3
	4 nurses X 7.45am to 8.30pm & 3 nurses 8.30pm to 7.45am and 1 cnm2 9am to 5.30pm	1	3.3
	1 nurse X 11.40 hours, 1 nurse x 8 hours, 1 nurse x12.40 hrs	1	3.3
	Total	30	100.0

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Table 27: (Household Staff No. & Hours Worked per 24 HR Residence

Household Staff No. & Hours Worked		Frequency	Percent
Valid	0	12	40.0
	2 household doing 37.5 hrs each	2	6.7
	A Household person on duty 24 hrs per day	2	6.7
	1 Household staff member 8.30 to 18.30	1	3.3
	1 Household staff member 10.00am to 4.00pm	1	3.3
	1 Household working 09:00 to 5:30pm	1	3.3
	1 Household staff member working 8am to 8pm	3	10.0
	1 Household staff member 7.5 hrs	2	6.7
	1 Household staff member 11am - 6pm	1	3.3
	1 household 12 hours and 1 household 10 hours	1	3.3
	1 Household staff member working 6 hrs	1	3.3
	1 Household staff working 13.5 hrs	1	3.3
	1 Household staff X 7.8 hrs early, 1 HH Staff x 7.8 hrs late, 1 HH staff X 11.25 night	1	3.3
	1 household 8 hrs	1	3.3
	Total	30	100.0

73.3% (n = 22) of Residences responded that staff do not 'Rotate at Set Intervals'.

From the Residences that Staff do Rotate at set intervals 6.7% indicated 'staff rotated yearly', 6.7% 'every 2 years', 3.3% 'every six months' and 3.3% 'some 6 mths, some yearly and some, 2 yearly.

4.14.5 Assessment / Admission to Residence

Staff of the Residences were asked a number of questions focused on 'Assessment and Admission' to the Residence.

63.3% (n = 19) undertake a 'formally structured assessment' of Residents prior to Admission. 30% (n = 9) responded that an assessment took place however, it was 'not formally structured' with the remaining 6.7% (n = 2) responded that 'no' assessment took place.

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Places in the Residence

16.7% (n = 5) of Residences had 'Designated Respite Beds'. 83.3% (n = 25) of Residences were not used to accommodate transfers from the acute unit due to bed shortages. With the remaining 16.7% (n = 5) indicating that the Residence was used for these transfers. 46.7% (n = 14) of Residences did not have a policy for admission to 'Respite Beds', 66.7% (n =20) did not have a policy for admission to 'Crisis Beds' and 66.7% (n = 20) did not have a policy for admission of transfer from the acute unit.

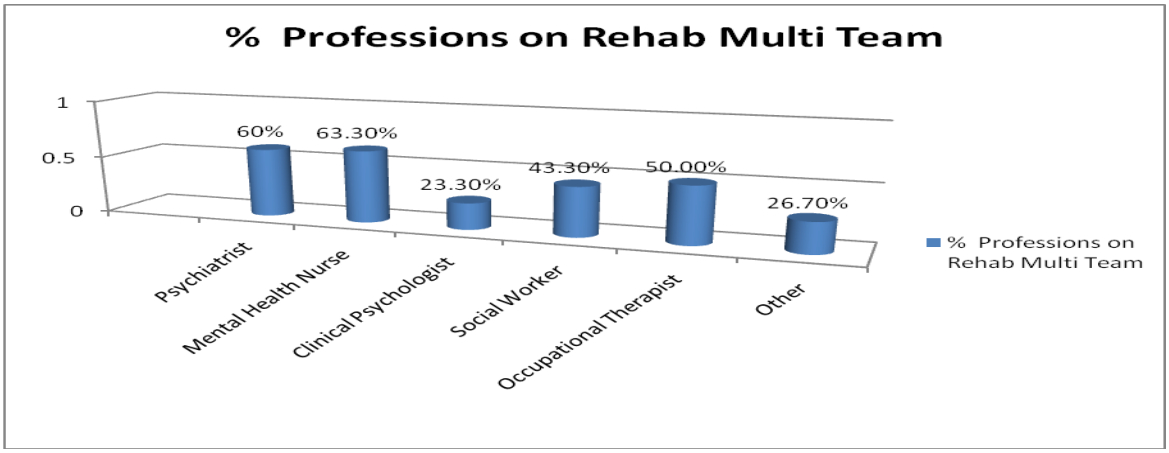
83.3% (n = 25) of Residences did not have a 'waiting list'. Of those that did, 6.7% (n = 2) had a waiting time of '15 weeks', 3.3% (n = 1) had a waiting time of '4 weeks' 3.3% (n = 1) had a waiting time of '52 weeks' and 3.3% (n = 1) had a waiting time of '156 weeks'. In total there were 17 applications on the waiting lists.

56.7% (n = 17) responded that there was a specialised rehabilitation team for the service. 40% (n = 12) indicated that the Rehabilitation team had ownership of beds in the Residence.

Decisions on placement, discharge or transfer of patients were made (a) Specialised Rehabilitation Team – 30% (n = 9) of Residences indicated 'Yes', (b) Individual's Care Team – 46.7% (n = 14) indicated 'Yes', (c) Specialised Rehabilitation team and patient's own team – 26.7% (n = 8) indicated yes.

60% (n = 18) responded that the 'Specialist Rehabilitation Team' was Multidisciplinary. With the following professionals on the team.

Figure. 5: - Professions on Rehabilitation Multid Team in 60% (n = 18) Residences



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Asked if there was a 'professional admitting diagnosis drawn up once a patient has been admitted- 50% (n = 15) of Residences indicated that this was drawn up within 'one week to one month' 3.3% (n = 1) indicated it was drawn up 'in less than three months from admission', another 3.3% (n = 1) indicated within 'one to three months'.

23.3% (n = 7) of Residences answered 'No' to this question, i.e. 'a professional admitting diagnosis is not drawn up on admission or in the subsequent period outlined above.

100% (n = 30) of Residences responded that 'all residents have an individual care and treatment plan with a clear aim.

Table 28: Inclusions in Individual Care Plan – 24 HR Community Residences

Does ICP include:	**Yes % (n =)**
The specific medical treatment	86.7% (n = 26)
The responsibilities of each member of the treatment team	70% (n = 21)
Adequate documentation to justify diagnosis	86.7% (n = 26)
The treatment and rehabilitation activities carried out	86.7% (n = 26)

100% (n = 30) responded that Care Plans are reviewed by those responsible for the Care of the Resident.

Asked if an admission form is to be signed by the resident/and or family members containing details on treatment goals and the residential unit process and procedures 63.3 (n = 19) responded 'Yes'. However, 33.3% (n = 10) responded 'No' to this question. 100% (n = 30) of the Residences responded 'Yes' when asked if a qualified professional is assigned to each resident that the resident can refer to throughout their treatment.

4.14.5.1 Exclusion Criteria

Residences were asked by indicating 'Yes or No' which, if any, of a number of

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Criteria were used as 'Exclusion Criteria' for the Residence:-

70% (n = 21) of Residences did not have an Exclusion Criteria for 'Acute Psychotic Disorders', with 26.7% (n = 8) indicating this diagnosis was used as an Exclusion Criteria. 70% (n = 21) also indicated that a 'history of substance abuse' was not used as an Exclusion Criteria, the same percentage (70%) also did not have Alcohol Abuse as an Exclusion Criteria. Severe Physical Disease was not an Exclusion Criteria for 56.7% (N = 17) but was for 43.3% (n = 13), Organic Brain Disorder was not an Exclusion Criteria for 56.7% (n = 17) but was for 36.7% (n = 11).

63.3% (n = 19) did not have an Exclusion Criteria for Intellectual Disability, with 30% (n = 9) indicating that ID was Exclusion Criteria. A History of Violent Behaviour was not an Exclusion Criteria for 70% of Residences (n = 21) and was for 26.7% (n = 8), 90% of Residences (n = 27) did not have an Exclusion Criteria for Former Residents of Psychiatric Hospitals and 80% (n = 24) did not have an Exclusion Criteria for Former Residents of Forensic Hospitals.

4.14.6 Evaluation / Procedures

56.7% (n = 17) of 24 HR Residences responded that they did not compile an 'annual planning report' for the Residence. 60% (n = 18) did not have an evaluation plan underlining the 24HR Residence's quality services and controls. From the 33.3% (n = 10) of Residences that confirmed they did have an evaluation plan underlining the quality services and controls, the following represents what they indicated was included.

Table 29: Inclusions in Evaluation Plan – 24 HR Community Residences

Included in evaluation plan – quality services & controls	**Yes % (n =)** **(From 33.3% who indicated they had the plan in place)**	**No % (n =)** **(From 33.3% who indicated they had the plan in place)**
Performance Indicators Monitoring System	16.6% (n = 5)	16.6% (n = 5)
Clinical Evaluation of medical conditions examined by using designated evaluation tools	23.3% (n = 7)	10% (n = 3)

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Surveillance of certain situations or problematic situations	26.7% (n = 8)	6.7% (n = 2)
Evaluating residents satisfaction	26.7% (n = 8)	6.7% (n = 2)
Evaluating residents' family satisfaction	16.7% (n = 5)	16.7% (n = 5)
Integrated Evaluation within programmes jointly co-ordinated with other services	6.7% (n = 2)	23.3% (n = 7

53.3% (n = 16) of Residences responded that there is a 'Clinical Psychosocial Evaluation Procedure' to assess Residents. The evaluation procedures used included:-

- Camberwell Assessment of Need
- Individual Care Plan Review
- CASIG
- Sainsbury Risk Assessment + Camberwell Assessment of Need
- Recovery STAR assessment Tool
- Social Functioning Questionnaire / Nursing Progress Report / Risk Assessment
- Biopsychosocial Core Assessment

Table 30: Provision of Information to Residents

Provision of Information	**Yes % (n =)**	**No % (n =)**
Is there a procedure to take into account residents and families feedback?	66.7% (n = 20)	20% (n = 6)
Is an information pack given to residents on admission (residence rules and regulations, policies and procedures booklet?	40% (n = 12)	50% (n = 15)
Are residents given information on emergency telephone numbers?	60% (n = 18)	33.3% (n = 10)
Are residents given information on rights?	66.7% (n = 20)	26.7% (n = 8)

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Are residents provided with information on the complaints procedure?	86.7% (n = 26)	2% (n = 6.7%
Are residents informed of the name of the local complaints officer?	80% (n = 24)	13.3% (n = 4)
Are residents informed of the Mental Health Commission (including role and functions in mental health services)	80% (n = 24)	13.3% (n = 4)

4.14.7 Characteristics / Profile of Residents

There were a total of 350 Residents living in the 24 Hour Residences (n = 30) based on the completed questionnaires. Of the total residents 53% (n = 185) were male and 47% (n = 165) were female.

- 35% (n = 123) of the Residents were over 65 years - 60 male and 63 female.
- 29% (n = 102) were aged 56 – 65 years – 55 - male and 47 female.
- 19% (n = 68) were aged between 46 – 55 years – 36 male and 32 female.

The remaining profile was 8% (n = 28) were in the 36 – 45 age group (15 male, 13 female), 3% (n = 11) were in the 26 – 35 age group (7 male and 4 female) and 1% (n = 4) male residents were in the 18 – 25 age group, with no female residents in this group.

Out of the total 350 Residents in the Residences 52% (n = 182) were admitted or came to live in the Residence over 36 months ago. 15% (n = 53) came to the Residence over 13 and under 36 months ago. 11% (n = 38) came into the over 6 months and under 12 month category with 9% (n = 33) coming to the Residence in the past six months. A timeframe was not provided for the remaining 13% of the Residents.

A total of 41 Residents were discharged in the past twelve months, based on the total Residents number for this study i.e. n = 350 that would represent 12%. In the same period i.e. 12 months there were a total of 4 re-admissions to the Residences.

The above 41 discharged (last 12 months) Residents went to:-

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- 12 Residents went to health unit with the same level of support
- 10 Residents went to a health unit with a lower level of support
- 6 Residents when discharged went to Hospice care
- 6 went back to live with Family
- 6 went to Home

40% (n = 140) of Residents attended a Day Centre, whereas out of a total of 350 Residents only 3 attended a Day Hospital.

Only 11 Residents in total were in full time sheltered employment, with 4 in full time paid employment and 2 in part time supported paid employment in the community.

4.14.8 Main Diagnoses of Residents (%)

Table 31 (a) : Main Diagnoses of Residents (%)

		Q9 % Organic Disorders	Q9 % Addiction/ Abuse	Q9 Schizophrenia	Q9 % Schizo-affective disorders
N	Valid	28	27	28	27
	Missing	2	3	2	3
Mean		1.80	.37	**48.58**	14.53
Std. Deviation		3.367	1.925	26.894	20.007
Range		10	10	94	84

Table 31 (b) Main Diagnoses of Residents (%)

Q9 % Affective Disorders	Q9 % Somatoform/psychosomatic disorders	Q9 % Eating / Sleeping Disorders	Q9 % Personality Disorders	Q9 % Other
27	26	26	28	28
3	4	4	2	2
12.84	1.92	.00	1.86	18.39
13.421	7.359	.000	5.829	38.797
35	35	0	25	100

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4.14.9 Therapeutic Activities Provided

4.14.9.1 Vocational Training

53% (n = 16) of Residences indicated 'Vocational Training' as a therapeutic activity. A nurse and/or OT provided this in 17% of residences. In 36% of residences this was provided by a mix of 'Nurse, OT, Social Groups and Volunteers and Others.
In 30% of cases vocational training was provided 'Outside the Residence', 20% 'both inside and outside' the residence and 3.3% 'inside the residence.

4.14.9.2 Sheltered Work

36% (n = 11) of Residences indicated 'Sheltered Work' as a therapeutic activity. Social Groups, Volunteers and others provided this in 23.3% (n = 7) of Residences. With either a nurse inside or 'others' outside providing in 13.4% (n = 4) of the Residences. In 33.3% (n = 10) of the Residences 'Sheltered Work' was provided 'outside the residence', with the remaining 3.3% (n = 1) providing it 'inside'.

4.14.9.3 Supported Work in the Community

26% (n = 8) of the Residences indicated 'Supported Work in the Community' as a therapeutic activity. This was undertaken by the O.T, Social, Groups, Volunteers and others, outside of the Residence.

4.14.9.4 Cognitive Behavioural Therapies

46% (n = 14) of the Residences indicated 'Cognitive Behavioural Therapies' as a therapeutic activity. This was undertaken mainly by nursing staff 36.6% (n = 11), with 10% (n = 3) of Residences indicating 'Others' provided this therapy for Residents. In over 50% of cases this was undertaken 'outside of the residence',

4.14.9.5 Practical Living Skills

80% (n = 24) of Residences indicated that 'Practical Living Skills' was a therapeutic activity which was undertaken. In 33.3% of Residences this was undertaken by the Nursing staff, with a further 23.3% indicating both Nursing Staff and the O.T. provided this activity. In the

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remaining 16.6% of Residences it was undertaken by a mix of the Nurse, Social Groups, Volunteers and Others. The activity was undertaken in half of the Residences 'inside' and half 'outside'.

4.14.9.6 Social Skills

Again, 80% of Residences indicated that 'Social Skills' was provided as a therapeutic activity. In 36.7% (n =11) of Residences this was provided by the nursing staff', with a further 20% (n = 6) indicating both the nursing staff and OT staff provided this therapy. Again, the location for the provision of the therapy was a mix between inside the residences and outside the residences in 56.7% (n = 17) of Residences.

4.14.9.7 Budgeting skills

76% (n = 23) indicated that 'Budgeting Skills' were provided to Residents. In 53.3% of Residences (n = 16) these were provided by the nursing staff. With a further 23.3% (n = 7) provided by a mix of nursing, OT, Social groups and volunteers. The location was a mainly a mix of both inside and outside most of the Residences.

4.14.9.8 Physical Activities

76% (n = 23) of Residences indicated 'Physical Activities' were provided. These were mainly undertaken by nursing staff, 40% (n =12) of residences indicated nursing staff alone with 36% undertaken by a mix of nursing, OT, Social groups, volunteers and others. 56.7% of Residences indicated that these were carried out
both 'inside and outside the residence, with 16.7% responding 'inside the residence' alone and 16.7% indicating 'outside the residence.

4.14.9.9 Alcohol Addiction Counselling

47% (n = 14) of Residences provided 'Addiction Counselling' to Residents. With 'nursing staff' and others providing in the majority of cases both inside and outside the residence.

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4.14.9.10 Family Education Support Counselling

70% (n = 21) of Residences provided Family Support Counselling, in 50% of residences this was providing by the Nursing Staff.

4.14.9.11 Leisure Activities

76% (n = 23) of Residences indicated the provision of 'Leisure Activities'. This was provided by a mix of nursing staff, social groups, volunteers and others. Again, this was provided both inside and outside the residences.

4.14.9.12 Physiotherapy

30% of Residences provided physiotherapy to Residents.

4.14.9.13 Initiate Activities that would involve Members of the Community

60% (n = 18) or Residences responded that they 'initiate activities that involve members of the Community.

4.14.9.14 Promote participation in integrated social activities in the community

80% (n = 24) confirmed that they 'promote participation in integrated social activities in the community.

4.14.9.15 Promote participation in events organised by community groups

83.3% (n = 25) of Residences responded that they 'promote participation in events organised by community groups'.

4.14.9.16 Facilitate residents going back to work informally to help improve social Integration

50% (n = 15) indicated that they 'facilitate residents going back to work informally to help improve social integration'.

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4.14.9.17 Facilitate residents finding work through employment agency, regional and local enterprise agencies.

43.3% (n = 13) Residences confirmed that they 'facilitate residents finding work through employment agencies, regional and local enterprise agencies'. 23.3% (n = 7) responded 'no' to this question and 30% (n = 9) did not indicate either way.

4.14.9.18 Facilitate re-housing

60% (n = 18) Residences indicated that they 'facilitate re-housing of residents.'.

4.14.10 Communication / Mental Health Policy

4.14.10.1 Level of Communication between 24 HR Residences and Day Hospital

70% (n = 21) of 24HR Residences responded to this question and rated their level of Communication with the Day Hospitals in their area on a Likert scale of 1 to 5 with 1 representing 'poor communication' and 5 representing 'excellent communication'. 20% (n = 6) of 24 HR Residences rated the communication levels with the Day Hospitals in their area as 'Satisfactory', 13.3% (n = 4) rated it as 'Very Good' with a further 13.3% (n = 4) giving a rating of 'Excellent'. The other ratings provided were 10% indicating that Communication was 'Good' and 10% rating it as 'Poor'.

4.14.10.2 Level of Communication between 24HR Community Residences and Day Centres

86% (n = 26) of 24 HR Residences responded to this question and rated their level of Communication with the Day Centres in their area on a Likert scale of 1 to 5. 40% of 24 HR Residences rated the level of Communication with Day Centres in their area as 'Excellent', a further 23.3% rated it as 'Very Good'. 10% gave a rating of 'Good', 10% also gave a rating of 'Poor' with the remaining 3.3% rating communication as 'Satisfactory'.

4.14.10.3 Level of Communication between 24 HR Residences and Approved Centres

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93% (n = 28) of 24 HR Residences responded to this question and rated their level of Communication with the Approved Centres in their area on a Likert scale of 1 to 5. 36.7% (n = 11) of 24 HR Residences rated the level of Communication with Approved Centres in their area as 'Very Good', a further 23.3% rated it as 'Good' 20% gave a rating of 'Satisfactory'. 10% rating as 'Excellent' with the remaining 3.3% rating communication as 'Poor'.

4.14.10.4 Level of Communication between 24 HR Residences and and Primary Care Network

33.3% (n = 10) rated communication with their Primary Care Network as 'Very Good', a further 23.3% rated it as 'Good'. The remaining ratings were 20% 'Satisfactory', 6.7% 'Excellent' and also 6.7% gave a 'Poor' rating.

4.14.11 Mental Health Policy / Service Provision Ethos

4.14.11.1 Advocacy & 24HR Community Residence Service Provision

24HR Residences were asked to outline how Residents accessed Advocacy Services.
33.3% (n = 10) of 24HR Residences responded that an 'Advocacy Officer can meet a Resident if required, information is also made available', 10% (n = 3) responded that 'member of advocacy group attends on a regular basis, each resident given advocacy information and contacts'. Other responses included: (i) Advocates visit Residence every few month, (ii) Primarily through designated Social Worker, (iii) Information on advocacy given to Residents, no visit from Advocates to the Residence, Residence involved in social groups who make representations on behalf of the Residents,(iv) Contact Regional Advocate, Irish Advocacy Network information on unit, (v) the Residence extends invitations to GROW Support Group and Advocacy Services, (vi) Through nursing staff if required and (vii) Residents receive letters and information from Advocacy Service and can contact if they wish.

As referred to earlier Chapter 4 Part D details feedback from Peer Advocates on Community Mental Health Services and in particular, their work in Day Hospitals and Day Centres.

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4.14.11.2 Involvement of Service Users in Designing and Developing Services

Respondents were asked to outline how Residents are involved in designing and developing services.

30% (n = 9) of Residences responded that Residents are involved in the design and development of services through 'meetings which take place with Residents', 13.3% (n =4) considered the 'Care Plan Review' which takes place with Residents as a mechanism to also seek their views on the design and development of the service. 10% (n =3) responded that Residents are 'not involved' in service design and development. 6.7% (n = 2) stated Residents are involved 'through Sector Meetings, NSUE Audit, care plan process to identify service deficits. Other responses included: (i) community meeting facilitates residents input, plan and development of community access group, (ii) Consumer Panels, care plans, (iii) Care Plans/peer advocates/collaborative planning/consumer driven goals, (iv) Advocate representative on planning committees/residents meetings, and (v) involved in designing activities and programmes, feedback which shapes the way services are delivered.

4.14.11.3 Permeation of Recovery Approach in 24 HR Community Residences

Table 32 overleaf represents responses on how the Recovery Approach permeates Service Provision in 24 HR Staffed Residences.

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Table 32: Permeation of Recovery in 24 HR Residences

		Frequency	Percent	Valid Percent	Cumulative Percent
	Try to help and support residents to move to low and medium support or independent living however few suitable	1	3.3	4.3	4.3
	Residents are more empowered through input in their ICP and more aware of their rights	1	3.3	4.3	8.7
	The recovery approach as visualised in Planning For The Future stagnated and did not progress in A Vision For Change	1	3.3	4.3	13.0
	Promotion of Independence, choices, options, family involvement, access to mdt, Icp	1	3.3	4.3	17.4
	Service delivered with Recovery approach ethos / balance between rec and prof accountability can be fine	4	13.3	17.4	34.8
	Recovery ethos, encouragement of self management and empowerment	8	26.7	34.8	69.6
	Residents involved in service, feedback sought to ensure service meets expectations, care planning, empowerment, choice	2	6.7	8.7	78.3
	Recovery approach to the fore, some residents do not wish to engage in community integration	1	3.3	4.3	82.6
	Multi d input, individualised patient centred approach, social integration independence	1	3.3	4.3	87.0
	empowerment of the residents, promoting therapeutic relationships focused on hope and recovery	1	3.3	4.3	91.3
	Care plans are focused around recovery model, emphasis on strengths and future goals	1	3.3	4.3	95.7
	Recovery model used in unit and all staff promote same	1	3.3	4.3	100.0
	Total	23	76.7	100.0	
Missing	System	7	23.3		
Total		30	100.0		

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4.15 RESULTS - PART D - PEER ADVOCATES

The Irish Advocacy Network is a Peer Advocacy Organisation. At the time of this study there were 18 Peer Advocates working for IAN in the 26 counties of Ireland. The advocates mainly visit Approved Centres, however, they also visit Day Hospitals and Day Centres.

A Peer Advocate Questionnaire focused on Day Hospital and Day Centre Community Mental Health Services was e-mailed to each of the Peer Advocates working for IAN.

Seven of the Peer Advocates completed and returned the questionnaire representing a response rate of 38%.

4.15.1 Percentage of Advocacy Work time spent in Day Hospital Settings

Respondents were asked what percentage of their advocacy work time was spent in Day Hospital Settings.

All respondents answered this question (n = 7). 57% (n = 4) of the Peer Advocates responded that 10% of the Peer Advocate work is spent in Day Hospital settings. 28% (n = 2) indicated that 20% of their Peer Advocate work takes place in Day Hospital Settings, with 14% (n = 1) spending 50% of their time in Day Hospitals.

4.15.2 Percentage of Advocacy Work time spent in Day Centre Settings

Respondents were asked what percentage of their advocacy work time was spent in Day Centre settings.

All respondents (n = 7) answered this question. 28% (n = 2) indicated that 10% of their Peer Advocate work time is spent in Day Centre Settings, 14% (n = 1) indicated that Day Centre work accounts for 20% of their time, 28% (n = 2) indicated 30% of their time and 14% (n = 1) indicated 50%.

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4.15.3 Communication

4.15.3.1 Communication with Day Hospitals

Peer Advocates were asked to indicate the level of communication that exists between them in their role as an Advocate and the Day Hospital Staff in general. The possible ratings were 'Poor' / 'Satisfactory' / 'Good' / 'Very Good', / 'Excellent' 28% (n = 2) rated communication as 'Very Good' with the Day Hospital, a further 28% (n = 2) rated it as 'Good', 14% (n = 1) rated communication as 'Excellent', 14% (n = 1) rated it as Satisfactory and the remaining 14% (n = 1) rated it as Poor.

4.15.3.2 Communication with Day Centres

As with the Day Hospitals, Peer Advocates were asked to indicate the level of communication that exists between them in their role as an Advocate and the Day Centre staff in general. As above, the ratings were 'Poor' / 'Satisfactory' / 'Good' / 'Very Good', / 'Excellent'

28% (n = 2) rated communication as 'Excellent' with the Day Centre, a further 28% (n = 2) rated it as 'Good', with 14% (n = 1) rating it as 'Very Good', and the same percentage i.e. 14% (n = 1) for both 'Satisfactory' and 'Poor'.

4.15.4 Accessing Advocacy Services

4.15.4.1 Peer Advocates were asked how Service Users accessed Advocacy Services in the Day Hospitals. The following represents the responses:-

"*Service Users Phone the Advocate to request appointment".*

"Posters with information regarding Irish Advocacy Network and contact number of peer advocate are up on notice board in common room/relaxation/training rooms and reception area in hospital. Staff members in the day hospital always draw service users attention to peer advocacy services".

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"In addition to regular visits the advocates contact details are displayed in waiting rooms and communal areas. Service users and make contact by phone".

"Many day hospital clients would have met me in the Acute units where I would give my contact number if wanted, leaflets and posters and contact details are availbe in the Day Hospitals where I also visit. I visit some Day Hospitals on an ad/hoc basis but some day hospital service users just to there to see a consultant or clinical nurse specialist and leave afterwards".

"They (Service Users) come up to me and talk to me or alternatively I meet them by appointment. When I arrive at the day hospital I normally introduce myself and say 'hello' to people, explain what I do and that anything that is said is said in confidence".

"Normally by requesting a meeting by telephone or through personal contact when I call to the Day Hospital".

"(1) By visitations I would visit the Day Hospital usually within a month and explain who I was and what the Advocacy Service provided, or on an adhoc basis if I get a phone call from a Service User.

(2) Service Users can access the service either by telephoning me through the Advocacy posters which has my full name and work number, and the Office number, my business card, or flyers.

(3) Service Users can be referred to me by Consultants and Charge Nurse Managers.

(4) By knowing me over time and building trust service users know they can ring me anytime".

4.15.4.2 Peer Advocates were asked how Service Users accessed Advocacy Services in the Day Centres The following represents the responses:-

The Peer Advocates mainly provided the same feedback on how Service Users accessed Advocacy Services in the Day Centres, there were two additional comments which are provided on page 101.

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“I visit some day centres and introduce myself to Service Users and leaflets and posters with contact numbers are on display for their use”.

“Normally through personal contact when I visit the Day Centre”.

4.15.5 Peer Advocates were asked if they thought ‘Advocacy Services’ are adequately, promoted by staff to Service Users in mental health community service settings.

57% (n = 4) of Peer Advocates responded that ‘Advocacy Services’ are not adequately promoted by staff to Service Users in mental health community settings.
With the remaining 42% (n = 3) indicating that they did think they were promoted sufficiently.

One Advocate further commented that in terms of promoting advocacy services, it depends very much on individual staff members. Certain staff seems to regard the peer advocate as a complaints person; others fully support the importance of peer support.

Other comments included that some staff are excellent and do promote the service. One respondent who considered that staff did promote the services indicated that there is still always room for improvement.

4.15.6 With regards to the level of involvement of Services Users in the design and development of services. Advocates were asked to rate as either ‘Poor’, ‘Satisfactory’, ‘Good’ ‘Very Good’ or ‘Excellent’.

All Advocates i.e. 100% (n = 7) rated the involvement of Service Users in the Design and Development of services as ‘Poor’.

Feedback included that ‘Service Users have little or no input in the design and development of services’

“In the area where I work, I know of very little service user involvement in any area of development. This is what I am told by service users and this is my own experience also. In many of the sectors where I work there are no service users on governance bodies, no service user involved to provide regular feedback to services”.

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"Awareness of innovate services in mental health needs to be generated among service users so that they do get an opportunity to participate in the design and development of services, it is not limited to what has always existed or their experience".

"The Mental Health Services in the sectors I cover have no difficulty in promoting whatever section(s) of A Vision for Change supports a specific decision while abjectly failing to consult the people who will be affected by those decisions i.e. Service Users. This situation makes nonsense of the core principles of A Vision for Change, the centrality of Service Users"

4.15.7 A lack of community based services has been highlighted in A Vision for Change. Peer Advocates were asked if, based on their experience there are adequate Day Hospital places available for Service Users.

42% (n = 3) of Peer Advocates responded that they do not think there are adequate Day Hospital places available. 25% (n = 2) responded that they think there are adequate places. This question as not completed on one questionnaire and on another an Advocate indicated that they 'didn't know' if adequate places were available.

Some views to the above included:-

"There have been lots of cutbacks in the amount of staff working in the services, staff shortages in acute settings and community settings have lowered the quality of care. The waiting time to see doctors and staff is very long in Day Hospitals".

"While A Vision for Change emphasised the provision of community based services, the reality is that Day Hospitals are run on a 9 to 5 basis; the out of hours services in some areas are good, but a lot more could be done to ensure that people are cared for in the community, and not in acute units".

"I have never received any complaints about the number of Day Hospital places in my sector".

4.15.8 In addition to the above question Peer Advocates were asked if they considered from their experience that there were adequate Day Centre places available for Service Users.

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28% (n = 2) responded that they did not think there are enough Day Centre places, with 14% (n = 1) responding that they thought there are and 56% (n = 4) did not indicated either way.

Some views pertaining to the above were:-

"Day Centres are more client-focused; they operate on a more personal level. That said, some of the activities provided are basic; and subject to funding and costs."
"I think in one of my catchment areas the pressure on Day Centre places is huge, and is not going to get any better if a unit in the ground of the hospital closes".
"While the answer to this question would be yes, I have received complaints about some Day Centres being oversubscribed i.e. too many Service Users for the size of the unit".

"Service users attending day centres enjoy the groups, the music sessions etc and some services report that having the staff caring the way they do makes their lives *worth living. A lot of the activities are thanks to the fundraising of staff and families".*

14.5.9 Peer Advocates were asked to rate on a Likert Scale from 1 to 5 with '1' representing 'not adequate' and '5' representing ' Excellent' in their opinion is a Recovery Ethos/Approach as recommended in A Vision for Change permeating service provision in Day Hospitals.

42% (n = 3) rated 'Not adequate' for the level of permeation of a Recovery Ethos/ Approach in Day Hospitals, a further 42% (n = 3) gave a rating of 'Adequate', with one respondent not providing a ranking.

Views expressed in relation to Recovery were as follows:

"This is a difficult question to answer because it depends on the individual Day Hospital. Some are more recovery focused than others. Nevertheless, if all of the Day Hositals are aggregated then the above response would be appropriate (rating 'Not Adequate')".

"Primary mode of service delivery as observed by the Advocate is still through forced biomedical model. Ignorance ranging from indifference to bordering on hostility still exists when the implications of the meaning of a Recovery/Ethos approach are raised although the advocate would not apply this to a generalised statement that is applicable to all staff in the advocates service area".

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"From my work I know there is a recovery approach being used but I see many people not recovering and re-admissions occurring over and over. If this approach was working well enough what is going wrong?. New service users often report to me their fear of never getting out of the psychiatric system once they are in it".

"I feel the recovery approach/ethos is only adequate. One issue is the lack of funding for services. Yet nurse managers do the best they can with the little funding they have. Also the voluntary organisations do come in once a week and provide a service. Also I know service users who would not use the same building in the evening time where organisations are holding meetings due to stigma, and might go to another area to avail of a meeting".

4.15.10 Peer Advocates were asked to rate on a Likert Scale from 1 to 5 with 1' representing 'not adequate' and '5' representing ' Excellent' in their opinion is a Recovery Ethos/Approach as recommended in A Vision for Change permeating service provision in Day Centres.

42% (n = 3) of advocates provided a rating of 'Adequate' for the level of permeation of a Recovery/Approach Ethos in Day Centres. A further 28% (n = 2) indicated a rating of 'Poor', with 14% (n = 1) indicating a rating of 'good'. One respondent did not provide a ranking.

Views expressed on Recovery in Day Centres were:-

" A lot of my work is in acute units and with service users living independently in the community but when I do work in Day Centres many of the service users are using the WRAP programme and others".

**Same view as provided for Day Hospital in additional comment below: "This is a difficult question to answer because it depends on the individual Day Centrel. Some are more recovery focused than others. Nevertheless, if all of the Day Centres are aggregated then the above response would be appropriate (rating 'Not Adequate')".*

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"The above proviso also applies (depends on the individual Day Centre). However, for reasons that will be expanded on in 'Additional Commentary below' Day Centres in my sector tend to be more recovery focused than Day Hospitals.".

The other views outlined above for Day Hospitals were highlighted by Respondents as equally applying to Day Centres.

4.15.11 Peer Advocates were asked to rate on a Likert Scale from 1 – 5 with 1 representing 'not adequate' and 5 representing 'excellent' the level of involvement of Service Users in the Care Planning process i.e. to what extent is 'Individual Care Planning' taking place.

42% (n = 3) considered the level of involvement of Services Users in the Care Planning process as 'adequate', 28% (n = 2) considered it to be 'good', equally the remaining 28% (n = 2) considered it to be 'not adequate'.

Views expressed regarding care planning are outlined below:-

"Care Planning is hit and miss. XMHS has introduced a new template that is very Good but it has only been implemented recently and time is needed to see what the outcomes are".

"The extent of service user involvement in individual care planning is difficult to gauge. Some have never heard of care plans; others are aware of them; but are unsure of what they are".

"This issue has been brought by me to staff's attention on numberous occasions. Sevice users very often report to me that they don't know what their care plan is. Staff have assured me that clients are signing their care plans and are involved but my personal opinion is that a lot of service users don't know they have a right to be the centre of their own care plan and have a right to have a copy of it. There may be many reasons for this but I believe service users should be reminded consistently throughout treatment that they are the 'Integral Individual' in this care plan".

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"Because I was involved in the Care Plan Evaluation carried out by the Mental Health Commission, in my sectors feedback from this process has improved service user involvement".

"The advocate does not believe that the continuation of the legally forcible use of the ICD-10 system in use in Ireland is compatible with a Recovery Approach/Ethos. If a person is free to choose an approach based on the ICD-10 system from a range of available approaches, then that to the advocate is compliant with a Recovery Approach/Ethos.

In cases where a client may have been identified or suspected as having Alzheimer's/ Dementia it has come to the advocate's attention that people may not be informed of this by a consultant psychiatrist and are not issued with a copy of their individual care plan. A person in some present cases may be deemed unknown to a peer advocate to be unable to give consent for the advocate to review their care plan with them. In such instances the peer advocacy model of advocacy is no longer truly affective or appropriate. The only form of advocacy that may be used in such a situation is Non Instructed Advocacy, but this form of advocacy is not yet properly supported or provided for. The advocate feels this is an area that needs to be urgently addressed given that Alzheimer's / Dementia is found to occur primarily in older age and the average age profile of the general population is set to become much older in the coming years according to census figures".

4.15.12 Now at a six year juncture into the implementation timeframe for A Vision for Change, Advocates were asked what were the most significant changes they had seen in Day Hospital service provision in that timeframe.

"Changes in sector headquarters, Primary care units being used for service provision. Closure of beds with not enough community services to support service users".

"Very little change the practices of the institutional hospital setting have been transferred to the day hospital settings".

"Service users have access to trained peer advocates. In some sectors admission rates are kept to a minimum. Information on a wide range of support groups is available and counselling and addiction services are in place.
"I think one of the most significant factors I have seen are in some cases Service Uses forming Service User Groups with the encouragement of Service Providers and Peer

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Advocacy. Also Service Users are more open and confident when a peer is involved in their situation. Service users have a voice either by encouragement to self-advocate or use their Advocate."

"Very little – people have been operating as they have always done with little change in the culture of the mental health services. Rules and regulations introduced by the Mental Health Commission has made people compliant but has failed to change the hearts and minds".

4.15.13 Now at a six year juncture into the implementation timeframe for A Vision for Change, Advocates were asked what were the most significant changes they had seen in Day Centre service provision in that timeframe.

"Day Centres in my sector have become more client focused'.

"Very little change the practices of the institutional hospital setting have been transferred to the day centre settings".

"It is difficult to identify significant changes in Day Centre service provision."

"There is no easy answer to this question as there is a multitude of factors which need to be addressed. Education, Funding, Staffing, Morale of Service Users themselves, Advocacy".

4.15.14 At this crucial juncture, what are the key drivers needed to facilitate change

"Key driver is good leadership, pushing out the boundaries in terms of best practice particularly with regard to innovative service provision that results in positive outcomes for the service user."

"Service users at the centre of the service. Voice of the consumer to be heard, their Opinions validated and respected. Service user (independent) questionnaires on what service users feel are the key drivers to facilitate change".

"One definition of change is "to become or make different". But "change" can only occur if that process is allocated sufficient financial and human resources. Unfortunately cutbacks to services create a situation whereby management are, understandably, concerned at the maintenance of the services they already operate. Equally, many health care professionals

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believe it's absurd to think about the provisions of A Vision for Change when they are apprehensive about staffing levels".

"The recovery approach has to be a key element of delivering change. The ethos of mental health services must be person-centred. Primary care centres need to be rolled out, and fully staffed. The over reliance on the medical model must be robustly challenged. Service users should be fully involved in decisions about treatment".

"More genuine service user involvement – not tokenism but valued - cover expenses (they are minimal). Peer led initiatives – outreach in the community. HSE has to be seen more in supporting initiatives that keeps people out of hospital. Focusing on quality of life for service users that they can maintain independently, rather than too much focus on medication."

"The advocate is of the belief that the current legally accepted forcible use of ICD/ DSM 'diagnosis' and labelling is wholly incompatible with A Recovery Approach. The continued monopoly based on these 'diagnostic systems' and held by bio-medical model psychiatry in being the sole determinators of whether or not an individual 'has a mental illness or disorder' and as to what this means in terms of what is legally acceptable under the law needs to be broken if a Recovery Approach/Ethos is to be truly implemented.

The existence of fundamental conflicts in interests involving the legally forced use of bio-medical model psychiatry, the law, our national educational systems and the pharmaceutical industry urgently needs to be acknowledged by all of the above mentioned and also brought to the wider attention of the general population and politicians.

The advocate believes that there is considerable room for development within the community development sector to help develop resources which may be of benefit to those experiencing emotional distress"

4.15.14 Additional feedback on community mental health services in Ireland.

"The quality of life for service users in community high support residences has decreased as 'normal everyday' activities have been curtailed. Some high support service users are concerned about the staff who have to do more and they are concerned if their homes will be closed. Staff not being replaced has affected service users in the community settings such as trips to buy clothes, get hair cut, recreational trips. Vision for Change I believed hoped to

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give service users the best quality of life in the community, however, in a lot of respects the severe cutbacks and staff shortages have negated this. The inclusion of mental health services in Primary Care centres has helped de-stigmatise mental health issues but many of these are not fully developed as yet. The quality of Rehabilitative care is decreasing in some places as there are not full MDT teams. The lack of Home Based Crisis teams at this stage is disappointing. In some acute units there are no Occupational Therapists not to mind in the community. I believe service users should be at every level of Service Development and to me this is hugely disappointing where the implementation of A Vision for Change is concerned after 6 years."

"The provision of mental health services in Ireland has definitely improved; however, the pace of change has been slow. While resources are a major factor in terms of service user service delivery; old attitudes still exist. The medical profession has yet to fully endorse the recovery approach to mental health treatment. A good number of the older mental health facilities have been closed; community mental health teams are poorly resources, and to not have the required compliment of staff."

With certain exceptions, in my sectors comparing Day Hospitals with Day Centres is akin to comparing an apple to a banana. Day Hospitals tend to be like large doctors waiting rooms. Clients are simply there to see their consultants. Day Centres however, have a regular clientele. They provide more structured activities and staff spend more time with clients. Because of these specific differences, I spend much more time in Day Centres. I understand that there are plans to expand the role of Day Hospitals and in one part of my catchment area the Day Hospital and Day centre have been combined. Which would seem to offer one model for future development of these units?"

"I have lots of ideas! Am working with service users to bring about positive change within the system".

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"We all have something to recover from, whether it is a mental illness, addiction, physical disability, loss of loved ones, victimisation or loneliness', , 'for change to occur, we must first recognise what we need to change' and 'Recovery creates a community that all can take part in as it erases the distinctions of position, age, skin colour, religion, language, and education and joins us in our common humanity. If we fail to recognise this capacity for recovery to unite us, we will have squandered a great opportunity to integrate our highly fragmented and siloed service systems"

Wesley Sowers, President of the American Association of Community Psychiatrists

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Chapter 5

5.0 Discussion & Conclusions

This study has profiled and examined the aims, organisational structure and content of service provision of three key community mental health service settings in Ireland. Moreover, doing so at a time of unprecedented change and seven years through the seven to ten year implementation timeframe of national mental health policy.

The study has provided information on some of the positive developments that have taken place within the past seven years and also some of the challenges that, although there has been increased awareness of, still remain unaddressed.

The study has identified that the same issues and developments both positive and challenging are applicable and pertain across the three service settings i.e. Day Hospitals, Day Centres and 24 HR Residences.

From Awareness to Behavioural Change

5.1 Recovery Ethos

One of the key principles and values central to *"A Vision for Change"* (7) is that a 'Recovery approach to mental health should be adopted as a cornerstone of mental health policy'. Recovery involves focusing on strengths and opportunities rather than on the limitations of illness. The concept of hope and optimism about outcomes are core in the recovery approach Developing the vision of recovery in mental health services has become increasingly important for service users and providers. The Mental Health Commission's publication *"A Recovery Approach within the Irish Mental Health Services – A Framework for Development" (81*) sets out the views of the Commission on recovery, as both a concept and practice and how it can become an integral part of Irish mental health services. At the time of its publication in 2008 mental health services in Ireland were generally only beginning to

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take on the challenge of incorporating the recovery philosophy into the organisation and design of services.

The responses received in this study demonstrate how the recovery approach has now become central to the thinking of staff working within the mental health services and more importantly that service users are expectant of a recovery oriented service.

However, translating and embedding the principles of recovery into the service being delivered is still a considerable challenge in many of the community service settings that participated in this study.

The importance of the Recovery approach was recognised by all three services. 89% (n = 41) of Day Hospitals, 92.6% (n = 25) of Day Centres and 76.7% (n = 23) of 24 HR Community Residences providing feedback on how Recovery permeates their service provision. However, the Peer Advocates that participated in the study commented that much depends on the individual service rather than an all encompassing philosophy being evident throughout services nationally.

5.2 Individual Care Planning

"A Vision for Change" (7) advocates the need for consultation with users and carers, in order to construct a comprehensive care plan. It further adds that care plans should be written and agreed between all parties, and includes a time frame, goals and aims of the user, the strategies and resources to achieve these outcomes and clear criteria for assessing outcome and user satisfaction.

Pertaining to in-patient settings an Individual Care Plan, as defined by the "*Mental Health Act 2001 (Approved Centres) Regulations 2006"* (82), is:

"a documented set of goals developed, regularly reviewed and updated by the resident's multidisciplinary team, so far as practicable in consultation with each resident. The individual care plan shall specify the treatment and care required which shall be in accordance with best practice, shall identify necessary resources and shall specify appropriate goals for the resident. For a resident who is a child, his or her individual care plan shall include education requirements. The individual care plan shall be recorded in the one composite set of documentation."

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In addition to the above legislative (inpatient settings) and policy requirements, the *"Quality Framework for Mental Health Services in Ireland*" (83) published by the Mental Health Commission in 2007 provides a clear framework of standards which providers of mental health services are expected to meet.
This includes **Standard 1:1:**

Standard 1.1 - "Each service user has an individual care and treatment plan that describes the levels of support and treatment required in line with his/her needs and is co-ordinated by a designated member of the multi-disciplinary team, i.e. a key-worker".

In addition, criteria for standards 1.2, 1.3, 1.5, 2.1, 2.2, 3.1, 3.2, 3.3, 3.4, 3.5, 4.2, 6.1, 7.3, 7.4 and 8.1 also relate to careplanning".

Table 33: Quality Framework for Mental Health Services in Ireland (84)
Standards Relevant To Care Planning

Theme	Standard Code	Standard
1. Provision of a holistic, seamless service and the full continuum of care provided by a multidisciplinary team.	1.2	Each service user experiences a planned entrance to and exit from every part of a mental health service.
	1.3	Each service user receives mental health care and treatment from a community based service that addresses the person's changing needs at various stages in the course of his/her illness.
	1.5	Therapeutic services and programmes to address the needs of service users are provided.
2. Respectful and empathetic relationships are required between people using the mental health services and those providing them.	2.1	Service users receive services in a manner that respects and acknowledges their specific values, beliefs and experiences.
	2.2	Service users rights are respected and upheld.
3. An empowering approach to service delivery is beneficial to both	3.1	Service users are facilitated to be actively involved in their own care and treatment through

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people using the service and those providing it.		the provision of information.
	3.2	Service users are empowered regarding their own care and treatment by exercising choice, rights and informed consent.
	3.3	Peer support/advocacy is available to service users.
	3.4	A clear accessible mechanism for participation in the delivery of mental health services is available to service users.
	3.5	Service users experience a recovery-focussed approach to treatment and care.
4. A quality physical environment that promotes good health and upholds the security and safety of service users.	4.2	Service users in residential or day settings receive a well-balanced nutritious diet.
6. Family/chosen advocate involvement and support.	6.1	Families, parents and carers are empowered as team members, receiving information, advice and support as appropriate.
7. Staff skills, expertise and morale are key influencers in the delivery of a quality mental health service.	7.3	Learning and using proven quality and safety methods underpins the delivery of a mental health service.
	7.4	The care and treatment provided by the mental health service is outcome-focussed.
8. Systematic evaluation and review of mental health services underpinned by best practice will enable providers to deliver quality services.	8.1	The mental health service is delivered in accordance with evidence-based codes of practice, policies and protocols.

5.2.1 80.4% (n = 37) of Day Hospital Respondents in this study answered 'Yes' to the question 'Do all Service Users of the Day Hospital have an Individual Care and Treatment Plan?' 100% (n = 30) of the 24 Hr Staffed Community Residence Respondents answered 'Yes' to this question. These percentages are certainly encouraging as to the increased level of awareness to the importance of care planning in general and in particular the development of Individual Care and Treatment Plans to which the Service User is a key contributor.

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Services also highlighted the Individual Care and Treatment Plan as a mechanism for Service Users to be involved in the design and development of services i.e. through continuous communication, feedback and input on the care and treatment provided by the service.

Notwithstanding the encouraging responses regarding Individual Care and Treatment Plans, without further analysis it is difficult to determine how involved service users really are in their treatment plans and if the plans are truly multidisciplinary.

5.3 Centricity of Service Users - Involvement of Service Users in Designing and Developing Services & Advocacy for Service Users

In Ireland, the voice of mental health Service Users has gained considerable momentum and been a catalyst for change particularly within the past ten year period. *"A Vision for Change"* (7) provided for the establishment of a National Service User Executive (NSUE) with the following mandate:

To inform the National Health Service Directorate and the Mental Health Commission on issues relating to user involvement and participation in:

- planning,
- delivering,
- evaluating and
- monitoring services -
    - and including models of best practice.

- To develop and implement best practice guidelines between the user and provider interface including capacity development issues.

The Irish Advocacy Network (IAN) also provides a peer advocacy service with 18 advocates nationwide aiming to facilitate user empowerment by supporting people and assisting them to live full and engaged lives. IAN was established in 1999 through Mind Yourself, a peer led and run advocacy organisation in Derry. IAN has been a force in establishing service user involvement and introducing the concept of recovery and peer support within HSE mental health services.

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It is a welcome development that services reported high levels of involvement by services users in the design and development of services. 95.6% (n = 44) of Day Hospitals, 96% of Day Centres and 83% of 24 HR Staffed Community Residences reported the involvement of service users in the design and development of services. Notwithstanding this, the manner in which service users were involved varied considerably as detailed in Chapter 4.

However, it is important to note that all Advocates i.e. 100% (n = 7) rated the involvement of Service Users in the Design and Development of services as 'Poor'. Feedback included that 'Service Users have little or no input in the design and development of services'

"In the area where I work, I know of very little service user involvement in any area of development. This is what I am told by service users and this is my own experience also. In many of the sectors where I work there are not service users on governance bodies, no service user involved to provide regular feedback to services".

There is certainly a significant communication gap that needs to be addressed which is evident by the differences between 'staff views' and 'advocate views' on a number of aspects of service provision.

5.4 Communication

It is encouraging to note that overall levels of communication between the various services were rated positively.

5.4.1 Communication with Approved Centres

81.4% (n = 22) of Day Centres rated the standard of their communication with Approved Centres in the range of 'Good / Very Good / Excellent'. 78.3% (n = 36) of Day Hospitals and 70% (n = 21) of 24 HR Community Residences rating communication in the same range.

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5.4.2 Communication with Day Hospitals

66.6% (n = 18) of Day Centres provided a rating of 'Good / Very Good / or Excellent' for the standard of communication with Day Hospitals in their area. However, only 36.6% (n = 11) of 24 HR Residences rated Communication within the 'Good / Very Good / Excellent range, with 30% (n = 9) rating it as Poor or unsatisfactory and the remaining 30% (n = 9) not providing feedback on this question.

5.4.3 Communication with Day Centres

70% (n = 21) of 24 HR Community Residences rated the standard of communication with Day Centres as 'Good / Very Good or Excellent'.

5.4.4 Communication with Primary Care Centres

85.1% (n = 23) of Day Centres rated the standard of Communication with Primary Care Centres in the range of 'Good / Very Good or Excellent', with 63.3% (n = 19) 24 HR Residences indicating the same range. 54.3% (n = 25) also indicated this range for the level of communication with 41% (n = 19) providing a 'Satisfactory or Poor' rating.

Challenges Still to Be Overcome

5.5 Leadership

The absence of dedicated leadership for the implementation process of 'A Vision for Change' (7) has been highlighted by many stakeholders including the Independent Monitoring Group for the Policy:-

> *"...the Independent Monitoring Group considers that the recommendations of A Vision for Change cannot be implemented effectively without a National Mental Health Service Directorate. The absence of a dedicated leader at senior, national level has impeded progress in the implementation of A Vision for Change and may be contributing to continuing poor facilities and standards of care in some areas and an inconsistent approach to embedding the recovery ethos in services. The Group recommends that the HSE should immediately appoint a leader of a National Mental Health Service Directorate to drive the implementation of A Vision for Change" (21)*

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It has taken seven years since the publication of the policy for steps to be taken towards addressing this serious deficit, despite the fact that international policy literature consistently highlights the importance of leadership to successful implementation (84), (85), (86).

Is the timing of moving towards this key appointment too late for Vision? A review of the policy which was recommended to take place in 2013 by the Independent Monitoring Group has yet to be commenced. In addition, already there is anecdotal evidence that a new 'Expert' group will be established before the end of 2013 to plan *'Vision's'* successor!.

5.6 Mental Health Information

The dearth of mental health information systems within the mental health services has been highlighted on numerous occasions and in particular by the Inspector of Mental Health Services. There is no national mental health information system, with mental health services around the country varying greatly in the information they collect, the manner it is collect and the ICT infrastructure available. All mental health information in Ireland is limited by the lack of a unique identifier for service users. There is especially limited information pertaining to community mental health services, as this information is not routinely collected.

5.7 Resources

The mental health services in Ireland are operating in a climate of unprecedented economic constraints. Ireland has been in a 'severe recession' (18) since 2008. The effects of the recession have been even more marked in Ireland because of the rapid and steep decline from a period of unprecedented growth which saw living standards increase by one-third in ten years (87). The recession has had a variety of economic effects. From a historically low level of unemployment; an average of 4.5% in 2007; unemployment has increased to 14.7% by the end of 2010.

The economic impact of mental health problems is considerable. The overall economic cost of mental health problems in Ireland has been estimated at just over €3 billion in 2006 (55), , which is equivalent to 2% of GNP. The bulk of the costs are located in the labour market as a result of lost employment, absenteeism, lost productivity and premature retirement. Costs to the health care system account for less than one quarter of overall costs.

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The publication of a *"Vision for Change" (7)* came at the cusp of the crisis, immediately after the publication of the policy all public spending was significantly cut. It must be acknowledged that the timing of the implementation of Vision was unfortunate as it came in line with an overall shortage of public resources and a requirement to reduce overall numbers employed in the public sector. Mental health policy and reform have been constrained by the current Public Service Moratorium on recruitment. Understaffed community mental health teams are a major stumbling block to policy implementation and the move to community based mental health services. The economic crisis is of course a cause of increased demand for mental health services at a time of shrinking budgets.

5.8 Summary

It must be acknowledged that the mental health landscape in Ireland has changed significantly in the past ten years both on a legislative and policy level. The awareness of the centricity of the service user in service provision is evident in the feedback which formed this study. However, it is widely recognised that a change process is needed to fully embed a person-centred approach to service provision. As outlined in the HSE's report "*New Directions*" (88) a person-centred approach to service provision requires a strong national vision, cultural change among providers and funders, support for innovation, funding systems that facilitate individual choice, and an expanded array of demand-led, individualised services that let service users exercise choice and control over decision-making about their service (88). Over the last seven years we have had the 'Vision' in the form of our mental health policy, however, the other elements have moved slowly, cultural change needs strong national leadership otherwise as has been the case, services end up working in stilos. This leads to inequitable service provision with, at best, pockets of 'best practice services' developing. These need to be recognised, encouraged, promoted and an opportunity for knowledge sharing seized. At present there is really a lost opportunity in this regard.

In addition, although there is a constant call for the move from institutionally based care to community care, there is insufficient focus on the community mental health services that are currently in existence and a dearth of information and research available. The work that is being undertaken in our Day Hospitals and in our Day Centres daily, needs to be highlighted and recognised. This study has provided an overview of service provision in these key community mental health service settings. Further research projects focused on

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the work of these important community service settings should be encouraged. The service settings which engaged in this study, did so very willingly and were open to participation in research which brings a greater understanding and focus on the services they provide.

Mental health in general and mental health service provision has come to the fore in recent years with constant media exposure, however, unfortunately, much of this is negative and does little to raise awareness of the extent of the work being undertaken in our services daily.

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APPENDIX 1:

Key Recommendations :
Department of Health & Children (2006) A Vision for Change Report of the Expert Group on Mental Health Policy (7)

Involvement of service users and their carers should be a feature of every aspect of service development and delivery.	Mental health promotion should be available for all age groups, to enhance protective factors and decrease risk factors for developing mental health problems
Well-trained, fully staffed, community-based, multidisciplinary CMHTs (Community Mental Health Teams) should be put in place for all mental health services. These teams should provide mental health services across the individual's lifespan.	To provide an effective community-based service,CMHTs should offer multidisciplinary home-based and assertive outreach care, and a comprehensive range of medical, psychological and social therapies relevant to the needs of services users and their families.
A recovery orientation should inform every aspect of service delivery and service users should be partners in their own care. Care plans should reflect the service user's particular needs, goals and potential and should address community factors that may impede or support recovery.	Links between specialist mental health services, primary care services and voluntary groups that are supportive of mental health should be enhanced and formalised.
The mental health services should be organised nationally in catchment areas for populations of between 250,000 and 400,000. In realigning catchment boundaries, consideration should be made of the current social and demographic composition of the population, and to geographical and other administrative boundaries.	Organisation and management of local catchment mental health services should be co-ordinated locally through Mental Health Catchment Area Management teams, and nationally by a Mental Health Service Directorate working directly within the Health Service Executive.
Service provision should be prioritised and developed where there is greatest need. This should be done equitably and across all service user groups.	Services should be evaluated with meaningful performance indicators annually to assess the added value the service is contributing to the mental health of the local catchment area population.
A plan to bring about the closure of all mental hospitals should be drawn up and implemented. The resources released by these closures should be protected for	Reinvestment in the mental health service.

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Mental health information systems should be developed locally. These systems should provide the national minimum mental health data set to a central mental health information system. Broadly-based mental health service research should be undertaken and funded.	Planning and funding of education and training for mental health professionals should be centralised in the new structures to be established by the Health Services Executive.
A multi-professional manpower plan should be put in place, linked to projected service plans. This plan should look at the skill mix of teams and the way staff are deployed between teams and geographically, taking into account the service models recommended in this policy. This plan should be prepared by the National Mental Health Service Directorate working closely with the Health Service Executive, the Department of Health and Children and service providers.	Substantial extra funding is required to finance this new Mental Health Policy. A programme of capital and non-capital investment in mental health services as recommended in this policy and adjusted in line with inflation should be implemented in a phased way over the next seven to ten years, in parallel with the reorganisation of mental health services.
An implementation review committee should be established to oversee the implementation of this policy.	*A Vision for Change* should be accepted and implemented as a complete plan.

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Appendix 2:

Synopsis of Recommendations – *Interim Report of the Steering Group on Review of Mental Health Act 2001* – It is important to Review the Full Report for additional 'Context' information (16).

Recommendation

The Group believes that a rights-based approach to mental health law should be adopted; unless there is evidence to the contrary, capacity should be presumed. A human rights based approach would underscore the fundamental rights of a person to participate in care and treatment decision making processes which affect them. Paternalism is incompatible with such a rights-based approach and accordingly the Act should be refocused away from 'best interests' in order to enhance patient autonomy.

It is recommended that the guiding principles of the revised Act should be human rights focused with the right to autonomy and self determination being the key principle. Other principles such as dignity, bodily integrity, recovery and least restriction should also be included and in this regard the Act should list a hierarchy of rights to guide decision making; this will ensure that there will be no carry over of paternalism into any new legislation. Further consideration is necessary as to the hierarchy of rights to be included which should involve in depth discussions with service users and other stakeholders.

Recommendation

The Steering Group believes that the focus of the inspectorate on the community based service should be increased. In order to achieve this within existing resources the Group recommends that the inspection interval for approved centres should be increased. It is suggested that approved centres should be inspected at least once every 3 years but flexibility should be built in to allow for more frequent inspection based on risk (such as size of centre and previous inspection history etc). The resource freed up by the less frequent inspection of in patient facilities should be utilised by increasing the rate of inspection of community based services. This may however necessitate the registration of community based services such as day hospitals, day centres and multi-disciplinary community teams.

Recommendation

It is recommended that recovery should be one of the guiding principles of the revised Act. The care planning function, which is already a statutory requirement in approved centres,

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should be strengthened and extended to all persons in receipt of mental health services. Care plans should reflect the service user's particular needs, goals and potential and should address community factors that may impede or support recovery. An in-patient should have an individual care plan at the earliest point following admission. This in essence would represent a discharge plan and would provide a seamless recovery based approach towards discharge and support in the community.

The Group also believes that establishing a legislative basis for Mental Health Advance Care Directives, which allow mental health service users to specify their treatment preferences in advance of an incapacitating mental health crisis, could serve to underscore *Vision's* recovery ethos. Such directives have the potential to enhance autonomy, empowering service users to participate in their future treatment decisions. The Department of Health is currently examining the need for legislation to provide a statutory basis for Advance Healthcare Directives. It is the view of the Group that legislative provisions for Mental Health Advance Care Directives should be included in any overarching legislation on Advance Healthcare Directives rather than be dealt with in isolation in Mental Health legislation. However, if it is decided not to proceed with such general legislation, the Group recommends that the revised Mental Health Act should include provisions relating to Mental Health Advance Care Directives.

Recommendation

The Group recommends that the provisions relating to Children should be included in a standalone Part of the Act and any provisions of the Child Care Act 1991 which apply should be expressly included rather than cross referenced. The dedicated children's Part of the Act should open with a set of guiding principles reflecting human rights principles enshrined in international human rights law including the United Nations Convention on the Rights of the Child. The Group notes that the guiding principles relating to children will of necessity differ from those relating to adults. The Group has proposed that the right to autonomy and self determination should be the key principles insofar as adults are concerned, but these cannot be the guiding principles for children. The Group accepts that paternalism will always be a necessary feature of mental health legislation relating to children but believes that due regard should be had to the evolving capacity of a child and the ability and the willingness of the child to be part of the decision making process.

While further consideration needs to be given to the content of these principles, the Group believes that the following are of importance:

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Admission of children should be decided in the context of the best interests of the child objectively assessed by reference to their rights

 the welfare of the child is the first and paramount consideration

 The views of the child should be heard and given due weight in accordance with the child's age and maturity

 The evolving capacities of the child should be respected

 The right to accessible and appropriate information

 The right to be treated in the least restrictive, and age appropriate setting

 The right to be treated in the least intrusive manner possible

 A specialised child advocacy service

The Department of Children and Youth Affairs should be further consulted as these principles are developed. This will ensure that any child policy issues which arise in the context of the proposed constitutional referendum on the child and in relation to obligations under international conventions, are fully considered.

Recommendation

The Steering Group recommends that children aged 16 or 17 should be presumed to have capacity to consent / refuse mental healthcare and treatment. The admission and treatment of Children under 16 requires the consent of the parent(s), however the views of the child should be heard and given due weight in accordance with the child's age and maturity.

Recommendation

At present the involuntary detention of a child requires a Court Order and the Group believes that this should remain unchanged i.e. any child under 18 should only be detained on foot of a Court Order. However the Group believes that the child should have the automatic right to an independent review of their detention and sees merit in the introduction of child friendly

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Tribunals for children detained by the Court. In addition a child should be provided with a legal representative. For children under 16, the parents should have a right of access to the Tribunal. The composition of the Tribunal and the review mechanism will need further consideration; however it is important that the Tribunal should have access to appropriate child expertise.

Recommendation

The Group recommends that the matter should be clarified by giving the Gardaí the specific power to remove a child believed to be suffering from a mental disorder to an age appropriate approved centre. (Further consideration is required regarding the provision of any necessary safeguards for the child in such circumstances). The HSE may then, if necessary and appropriate, initiate the process for the involuntary admission of the child.

Recommendations

The scope of the Mental Health Act should be extended to include voluntary patients and the protections provided for involuntary patients should where appropriate and necessary apply equally to voluntary patients. Further recommendations to this end are made in this report.

The Act should include a statement that a person is presumed to have capacity to make decisions in relation to admission and treatment. However, where there are reasonable grounds to believe that the patient lacks that capacity, arrangements should be made to assess the person's capacity to make a particular decision at that point in time, with a view to establishing the supports necessary to assist the person in making the decision. At present the treating psychiatrist determines the capacity of the patient to consent to treatment. Where the patient is deemed to lack capacity, that psychiatrist then makes any necessary treatment decisions. While accepting that the clinician providing care and treatment is well placed to determine the capacity of the patient, nonetheless the

Group believes that there is a need to establish independence in the capacity assessment. It is recommended that assessment of capacity should be undertaken by a trained mental health professional with multi-disciplinary input as necessary from the treating Mental Health Team. The Mental Health Commission should have a role in training and accrediting professionals in relation to capacity assessment.

Any new legislation should recognise that decisions on admission and treatment for persons who lack or have fluctuating capacity should be made in the context of the proposed

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capacity legislation i.e. the patient should receive all the necessary supports provided in that legislation to make a decision to be admitted and treated, up to and including substitute decision making. Substitute decision making should be applicable only as a last resort and even then the person charged with making the decision on behalf of the patient must be obliged to do so with regard to any known will or preferences of the patient.
The definition of voluntary patient should be amended such that a voluntary patient is a person who consents on his own behalf or with the support of others to admission to an approved centre for the purposes of care and treatment for mental illness, or on whose behalf a Personal Guardian appointed under the proposed Capacity legislation consents to such admission.

Essentially a voluntary patient may be:

1. a patient who has the necessary capacity to make a decision in relation to admission and a decision(s) in relation to treatment, and has consented to admission and treatment

2. a patient who has fluctuating capacity and requires support to make a decision in relation to admission and treatment

3. a patient who lacks capacity, and consent for admission and treatment has been provided by a Personal Guardian.

Recommendation

The Group is of the view that changing the legal status of a patient from voluntary to involuntary should not be undertaken lightly. To avoid the situation where a voluntary patient can remain as such in an approved centre refusing treatment provided they do not express a desire to leave, the Group recommends that acceptance of a need for treatment should be implicit in voluntary admission. On admission the informed consent of the patient to admission and a course of treatment should be required. Where a patient refuses the treatment offered the admission should not proceed. Where a voluntary patient refuses all treatment they should be discharged from the approved centre.

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Recommendation

The Group has already recommended that the guiding principles of the revised Act should be human rights focused, with the right to autonomy and self determination being the key principles. The Group further recommends that the Act should explicitly provide that patients should be supported to make informed decisions regarding their care and treatment. The need for such a statement, or the extent of any such statement, will need to be examined in the context of the forthcoming capacity legislation. However it is clear that treatment decisions in respect of all patients (either voluntary or involuntary) who lack or have fluctuating capacity, will be taken in accordance with the provisions of the capacity legislation i.e. by way of supported decision making or by a personal guardian appointed under that legislation.

In no circumstances should a patient who is capable of giving informed consent in relation to a particular decision at a given time be forced to take treatment against their will – accordingly 'unwilling' should be removed from Sections 59 and 60. This amendment will provide that where the person concerned has the capacity to make this decision, any refusal to accept ECT, or medicine after a continuous period of three months, will be respected.

The provisions of Sections 59 and 60 in regard to patients who are 'unable' to give consent will need further examination in the light of the proposed capacity legislation. The Group is hopeful that the protections provided to patients under that legislation will be sufficient and no further protections will be required under mental health legislation. Thus, it may be possible to repeal Sections 59(1) (b) and 60(b) of the Mental Health Act 2001.

Definition of Treatment:

The definition of treatment should be expanded to include ancillary tests required for the purposes of safeguarding life, ameliorating the condition, restoring health or relieving suffering.

Recommendations

The Group accepts that a person should be detained for treatment as a last resort and that the Act should be underpinned by the least restrictive principle, stressing that a patient should not be detained longer than absolutely necessary. It is recommended that any new legislation should explicitly require that all less restrictive options for care and treatment

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should be considered and exhausted before a person can be detained, and in the admission process, the admitting clinician should be required to certify that it is not possible for the person to receive the necessary care and treatment in the community. In line with the previous recommendation that the revised Act should incorporate human rights focused guiding principles, the autonomy principle should be central to the detention provisions in the Act.

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Appendix 3:

Recommendations of Independent Monitoring Group 6th and Final Annual Report (21)

Recommendations

12.1 Recommendations – Health Service Executive

- A National Mental Health Service Directorate as envisaged by AVFC must be established.
- Staffing of CMHTs should be continued as described in AVFC. A comprehensive, time-lined and costed Implementation Plan should be developed.
- Cultural issues such as personal attitude, professional policies and attitudes, philosophical biases, historical precedent and practice, should be addressed in any policy implementation process.
- Team working and shared planning should involve the service user and where appropriate family members.
- There should be a consistent national approach to the development and support of service users and family members.
- All mental health care services should be based on the fundamental principles and practices of recovery.
- In order to develop recovery oriented mental health services, all future activities should incorporate robust and independent evaluation.
- There is a need to ingrain the philosophy and practice of Recovery in the education of all clinicians involved in delivering mental health care.
- There us a need to ensure all mental health professionals are trained in the biological, psychological and social factors as well as in multidisciplinary work.
- There is a continuing need for training in care planning for all staff working in the area of mental health services.
- There is a need to ensure that all training involves service users and carers.
- There is a need to ensure that all health professionals have a sound knowledge of the appropriate use and possible side-effects of medications used in treating mental illness.
- The development of specialist mental health services in Psychiatry of Old Age, Intellectual Disability, Liaison Psychiatry, Eating Disorder, Comorbid Substance Abuse and Mental Illness, Neuropsychiatry, Borderline Personality Disorder should be prioritised as a matter of urgency.

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- Comprehensive annual reports for all mental health specialties should be developed on the lines of the CAMHS annual report.
- Rehabilitation and recovery mental health teams, as envisaged in AVFC, should be resourced and additional teams developed.
- The ICGP, CPI and health service providers should work to develop collaborative working relationships between primary care and mental health care services.
- A comprehensive social inclusion strategy with implementation timelines should be developed for those with mental health problems, as a priority
- Prison In-Reach teams and court diversion services for prisoners on remand should be developed nationally.
- The IMG strongly encourages the continued closure of inappropriate care settings.
- Models of personalised care should be developed in the new community based units which will reduce the risk of institutionalisation.
- A formal working relationship should be established with the independent mental health service providers.
- The proactive partnership between the HSE and the voluntary sector should be developed further to achieve full implementation of AVFC.
- The policies, services and practices agreed with the HSE and delivered by the voluntary sector should be aligned fully to AVFC.
- An action plan should be developed by the HSE to ensure that all existing mental health services become fully compliant with the current standards and regulations.

12.2 Recommendations - Government Departments

- Government Departments, other than the Department of Health and Department of Environment, Community and Local Government need to focus on their responsibilities for the implementation of AVFC.
- To ensure quality of psychological interventions, it is important that the Government pursues the statutory regulation of psychotherapy and counselling.
- An advocacy service which specifically responds to the needs of children and adolescents should be established by the Department of Social Protection in consultation with the Department of Children and Youth Affairs.
- Prison In-Reach teams and court diversion services for prisoners on remand should be developed nationally.

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12.3 Addressing the biological, psychological and social factors that contribute to mental health problems

- The work of the National Mental Health Services Collaborative on Care Planning should be continued and extended by the Partners to ensure the concept of care planning is embedded in all mental health services.
- Equal priority should be given to filling vacant allied health professional posts on multidisciplinary teams.
- The Department of Health with support from all relevant stakeholders including service users, carers, CPI, ICGP and Pharmaceutical Society of Ireland should develop a robust strategy to monitor, audit and report on the use and side-effects of drugs used in mental health treatment on a regional and national basis.
- The relationship between the medical profession (and to a certain extent the mental health nursing profession) and the pharmaceutical industry should be carefully monitored to ensure that undue influence does not arise.
- Future research in mental health services should be funded through nonpharmaceutical sources.
- Training of GPs, psychiatrists and, indeed, all multidisciplinary members should be funded from non-pharmaceutical sources and training of all clinicians involved in the delivery of mental health services be along biopsychosocial lines with particular emphasis on multidisciplinary working, service user involvement and the concept of recovery.

12.4 Recommendations – National Mental Health Programme (Clinical Programmes)

- The Principle of “Specialist within Generalist” Framework should be revised to ensure the development of separate specialist teams.
- The necessary staff resources and training should be made available to implement the National Mental Health Programme.
- The IMG would like to see a greater emphasis on Recovery as a core concept informing the Clinical Programme as it evolves and is rolled out.
- The National Clinical Lead and the GP Co-Lead should be full time posts.
- The Programme Plan should be further developed to ensure that it is fully consistent with AVFC.

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12.5 Recommendations – Recovery

- A Mental Health Service Directorate should be established with responsibility for the development and effective implementation of a plan to transform the mental health services in accordance with AVFC.
- The Directorate should prioritise the development of recovery-oriented practice in mental health services and should engage with all the stakeholder groups to agree a national co-ordinated strategy and implementation plan to achieve this objective.
- The strategy to achieve service and system level transformation must focus on the introduction of recovery-oriented practice in the key areas of service design and delivery, governance, training and evaluation.
- 'Recovery-proofing' the Human Resource practice within our mental health services is an essential component of transformation. The protocol for the recruitment of staff must clearly signal a commitment to recovery practice in the design of job descriptions and the inclusion of trained service users on the interview boards for staff recruitment.
- Monitoring of the implementation of AVFC must incorporate on-site assessment of reported activities to quality assure claims of recovery oriented practice and provide a measure of accountability for both funders and service users.
- Evidence-based/informed practice and values-based practice must become the bedrock of a transformed service model focussed on the implementation of recovery-oriented practice in mental health services.
- Service users and their families must be afforded the opportunity to avail of evidence-based/informed recovery-oriented programmes if they wish to use these tools to support their own recovery.
- Independent evaluation of programmes must be conducted by qualified personnel/bodies to support the development of a national evidence-base
  for recovery-oriented programmes and services in an Irish context.
- Care planning must develop into a system that can support service users
  unique needs, goals and recovery journey.
- Standardised outcome measures must be introduced to capture recovery as an outcome goal for services with consideration given to the
  introduction of recovery-oriented key performance indicators for services.
  The measures introduced must reflect a holistic perspective extending beyond symptom management to evaluating progress in respect of housing, employment, education and citizenship.

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- Standardised tools to support the assessment of recovery outcomes and facilitate recovery planning with the service user must be integrated into the Clinical Care Pathways and the care planning process.
- Recovery champions need to be encouraged, incentivised and empowered to drive change at national level and ensure they have the authority to achieve what is expected of them.
- Marketing the positive achievements of services, their staff, the service user and the broader community in adopting recovery practice is a priority.
- At national level, there is a need to formally recognise that the change to recovery practice is dependent on shifting beliefs, attitudes and behaviours. A range of measure will be required to support this evolving paradigm. Capacity-raising measures need to be a focal point in the recommended implementation plan for the new AVFC Mental Health Directorate. This should be supported by creating a dialogue internally within systems to enable a transformation process
- The area of training needs to be developed strategically and incorporated into the Implementation Plan of the AVFC Mental Health Directorate.
- Whilst recognising the need for broad competency-based training in many areas, training in the principles and practice of recovery needs to be incorporated into all in-house training in the HSE and in the professional training for students and professionals in the medical and allied health professional training courses run by professional bodies and universities including continuing professional development programmes.
- With appropriate training available, we recommend the introduction of the post of peer support worker within the HSE to ensure the expertise that people with self-experience is valued and not presume that this expertise will always be “volunteered”. Where opportunities arise to recruit new staff, the HSE should consider adopting practice from other jurisdictions where groups of employees have been explicitly recruited for their personal qualities rather than professional qualifications, which includes valuing their personal experience of mental health problems and services.
- The good practice and learning to date needs to generalise within the mental health services. Systems and processes to cascade the learning through the HSE must be established by the new AVFC Mental Health Directorate to ensure we standardise practice nationally.
- The publication of Guidance Papers by the HSE should continue as a practical support to local communities seeking to implement AVFC. These documents should seek to address the reported conceptual uncertainty and inconsistency regarding the meaning of recovery as it applies to practice in terms of delivering mental health services.

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- Opportunities to embed recovery principles in the current review of the Mental Health Act 2001, Criminal Law (Insanity) Act 2006 and future capacity legislation need to be fully explored

12.6 Recommendations – Monitoring of Implementation

The following options should be considered:

- The mandate of the present IMG should be extended to end of 2013 to allow it to conduct a comprehensive seven-year review.
- Authority be given to the MHC to conduct the seven year review in 2013 and to conduct yearly monitoring for the following three years.
- To enhance the work of the National Mental Health Service Directorate, a Special Delivery Unit for mental health should be established within the Department of Health.
- The implementation of AVFC should be strengthened by the provision of legislation which obliges Government and health service providers to plan, Develop and deliver mental health care services in accordance with the policy of AVFC.

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Appendix 4:

Questionnaire for the Assessment of Both Structural and Procedural Variables and Measures of Psychiatric Day Hospitals

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Questionnaire for the assessment of both structural and procedural variables and measures of psychiatric day hospitals

Organisation / Structure

1. Does your Day Hospital have a fixed number of places available?

- No ☐
- Yes ☐ If yes: ☐ places.

2. Description of Local Catchment Area your Day Hospital is responsible for:

- Population ----------
- Rural ☐ Small Town ☐ Large Town ☐ City ☐
- Rate of unemployment (% in 2011) ☐
- How many Day Hospitals exist in the local catchment area (of your Day Hospital) ☐
- How many Approved Centres (Hospital or Acute Unit in General Hospital) exist in the local catchment area ☐

  Total number of beds ☐

3. Is your Day Hospital located close to a psychiatric hospital (approved centre) or an acute psychiatric unit/department (approved centre) of a general hospital?

Day Hospital Rooms are situated:

- Inside the hospital buildings ☐
- On the hospital grounds ☐
  - Next to the hospital grounds ☐
- Within 15 minutes from the hospital by public transport ☐
- More than 15 minutes public transport from the hospital ☐

If more than 15 minutes, how many? ☐

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4. Where are your Sector Team headquarters located?

5. Was the Day Hospital Purpose Built?

Yes ☐ No ☐ Year Service Commenced: ☐

Please provide a brief description of the premises below:

6. Are these adequate to meet Service Needs?

On a scale of 1 – 5 please rate below if the Day Hospital premises meet Service Needs with 1 representing not adequate and 5 representing meets service needs well

1. ☐ 2. ☐ 3. ☐ 4. ☐ 5. ☐

7. Does your Day Hospital have access to a Crisis House in your Local Catchment Area.

Yes ☐ No ☐

If No, are there plans to establish such a facility

Yes ☐ No ☐

8. Service Users are expected to come to the Day Hospital:

- Every day from Mondays to Fridays ☐
- Depends on patients needs ☐
- If necessary, at the weekends too ☐

.

- Obligatory at the weekend too ☐
- Hours of Opening ☐

9. Is there a minimum time Service Users are expected to attend the Day Hospital every day?

- No ☐
- At least (in hours)

2 ☐ 4 ☐ 6 ☐ 7 ☐ 8 ☐

Concept and Diagnosis of Patients

10. Please rate aims and functions of your Day Hospital:

1 = no importance; 2 = moderate importance; 3 = medium importance; 4 = great importance; 5 = greatest importance

	1	2	3	4	5
• Service to shorten inpatient treatment	☐	☐	☐	☐	☐
• Alternative to inpatient treatment	☐	☐	☐	☐	☐
• Used for outpatient clinics	☐	☐	☐	☐	☐
• Addition to outpatient treatment	☐	☐	☐	☐	☐
• Crisis intervention	☐	☐	☐	☐	☐
• Psychotherapy	☐	☐	☐	☐	☐
• Rehabilitation for chronic disorders	☐	☐	☐	☐	☐
• Social Rehabilitation and Support	☐	☐	☐	☐	☐
• Other	☐	☐	☐	☐	☐

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11. What are the exclusion criteria for your Day Hospital?

(more than one answer as appropriate)

- Too long a distance to the Day Hospital ☐
- Does not have own accommodation ☐
- No motivation ☐
- Acute psychotic de-compensation ☐
- Acute suicidal ideations ☐
- Intellectual Disability ☐
- Drug Addiction / Abuse ☐
- Organic Disorders ☐
- Other ☐

12. Which of the following diagnostic procedures are routinely applied in the Day Hospital?

(more than one answer as appropriate)

	Yes	No
• Psychological Tests	☐	☐
• Blood Tests	☐	☐
• Urine Tests	☐	☐
• Physical Examination	☐	☐
• Neurological Examination	☐	☐
• Interviews of Relatives (Collateral history)	☐	☐
• Others	☐	☐

.

Staffing & Therapeutic Activities

13. How many staff work in the Day Hospital and what is their professional background? Please give the number of whole time equivalents for each professional group.

	No. of Staff	Working hours per Week
• Psychiatrists		
• Psychiatric Nurses		
• Psychologists		
• Occupational Therapists		
• Psychotherapists		
• Social Workers		
• Speech & Language Therapists		
• Administration (general management)		
• Secretarial		
• Other		

14. Which of the following therapeutic activities are provided in the Day Hospital? (Please answer Yes or No (Y/N)).

• Direct Day Structuring	
• Activation	
• Promoting Contacts	
• Social Skills Training	
• Training of every-day-living (eg. Cooking, household)	
• Music Therapy	
• Dance Therapy	
• Ergotherapy/occupational Therapy	
• Vocational Therapy	
• Planning of Leisure Time Activities	

.

• Psychiatric Nursing Activities	
• Psychological Interventions	
• Psychiatric-therapeutic talks	
• Individual Psychotherapy	
• Biological-psychiatric interventions	
• Interventions by somatic specialists (e.g. internists)	
• Assessing Social Problems	
• Counselling for Social Problems e.g. Work, living, Finance	
• Counselling for Lifestyle	
• Interventions during psychiatric crisis of patients	
• Outreach activities (e.g. home visits, if patients don't attend the Day Hospital)	
• Physiotherapy	
• Sporting Activities	
• Teaching in Coping with Simple Day Structure	
• Teaching in Handling Medication	
• Teaching in Coping with Symptoms	
• Other	

Characteristics of Service Users Treated in 2010 &/or YTD 2011

15. How many Service Users attended the Day Hospital in 2010 & YTD 2011

- Number of New Attendees 2010 ☐
- Total Number of Attendances 2010 ☐
- Number of New Attendees YTD 2011 ☐
- Total Number of Attendances YTD 2011 ☐
- Average No. of Daily Attendances ☐

16. What was the main diagnoses of Service Users in 2011 YTD in percentage

(Categories according to ICD-10)	%
• Organic Disorders (F0)	
• Addiction, abuse (F1)	

.

• Schizophrenia (F20)	
• Schizo-affective disorders (F25)	
• Affective Disorders (F3)	
• Somatoform/psychosomatic disorders (F45, F54)	
• Eating / Sleeping disorders etc. (F5)	
• Personality Disorders (F6)	
• Other	

17. Who referred Service Users to the Day Hospital in 2011 (in percentage).

	%
• Psychiatric Hospital (Approved Centre) / Acute Psychiatric Unit (Approved Centre)	
• Community Mental Health Services	
• Psychiatric Outpatient Service	
• Psychiatrist / Neurologist in private practice	
• Psychotherapist in Private Practice	
• General Practitioner	
• Patient herself/himself	
• Other	

Communication / Mental Health Policy

18. How would you rate the level of communication between your Day Hospital and Approved Centres in your area? Please tick as appropriate.

Poor ☐ Satisfactory ☐ Good ☐ Very Good ☐

Excellent ☐

19. How would you rate the level of communication between your Day Hospital and the Primary Care network in your area? Please tick as appropriate.

Poor ☐ Satisfactory ☐ Good ☐ Very Good ☐

Excellent ☐

.

20. In your opinion, is there an overlap between the services provided at Primary Care Centres and Day Hospitals?

21. How many Active Primary Care Teams are there in your local catchment area?

Number of Active Primary Care Teams: ☐

22. Do you think they complement the work of the Day Hospital?

Yes ☐ No ☐

Please provide any additional commentary you may wish to make below:

23. How do Service Users attending the Day Hospital access advocacy services?

24. How are Service Users involved in designing and developing services?

.

25. Do all Service Users of the Day Hospital have an Individual Care and Treatment Plan developed?

Yes ☐ No ☐

Please provide any additional commentary you may wish to make below:

26. A Vision For Change, Ireland's national mental health policy highlighted a lack of community based services for the delivery of high quality care and treatment, services such as Day Hospitals. Do you think there are adequate Day Hospital places as outlined in a Vision for Change available in your Catchment Area.

Yes ☐ No ☐

Please provide any additional commentary you may wish to make below:

27. Regarding Specialist Services such as Rehabilitative and Later Life do you think there are sufficient Day Hospital places available for such services?

Yes ☐ No ☐

Please provide any additional commentary you may wish to make below:

28. How does a Recovery Approach/Ethos as recommended in A Vision for Change permeate the service provision in your Day Hospital?

.

.

29. We are now six years into the implementation timeframe for A Vision for Change, what are the most significant changes you have seen in your Day Hospital service in this six year timeframe and at this crucial juncture of the implementation period, in your opinion what are the necessary key drivers to facilitate change.

30. If you would like to provide any other commentary on Community Mental Health Services in Ireland or in particular Day Hospital Service Provision your views would be most welcome.

.

I would like to take this opportunity to thank you for taking the time to complete this questionnaire, your time is very much valued and appreciated.

If you have any queries you can contact the Researcher (Marina Duffy) by e-mail at marina.duffy@mhcirl.ie or by phone on 087 9182869.

The questionnaire has been sent to you electronically for convenience and ease of return by e-mail. However, if it is your preference to complete the questionnaire by hard copy please return to the following marked strictly private and confidential and to be opened by the addressee only:-

Strictly Private & Confidential
To be Opened by the Addressee Only
Ms. Marina Duffy
Mental Health Commission
St. Martin's House
Waterloo Road
Dublin 4.

PLEASE RETURN BY : FRIDAY 16TH DECEMBER 2011

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Appendix 5:

Questionnaire for the Assessment of Both Structural and Procedural Variables and Measures of Mental Health Day Centres

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Questionnaire for the assessment of both structural and procedural variables and measures of Mental Health Day Centres

Organisation / Structure

1. Does your Day Centre have a fixed number of places available?

- No ☐
- Yes ☐ If yes: ☐ places.

2. Description of Local Catchment Area of the Day Centre:

- Population ----------
- Rural ☐ Small Town ☐ Large Town ☐ City ☐
- Rate of unemployment (% in 2011) ☐
- How many Day Centres exist in the local catchment area (of your Day Centre) ☐
- How many Approved Centres (Psychiatric Hospital or Acute Unit in General Hospital) exist in the local catchment area ☐

  Total number of beds ☐

3. Is your Day Centre located close to a psychiatric hospital (approved centre) or an acute psychiatric unit/department (approved centre) of a general hospital?

Day Centre is situated:

- Inside the hospital buildings ☐
- On the hospital grounds ☐
- Next to the hospital grounds ☐
- Within 15 minutes from the hospital by public transport ☐
- More than 15 minutes public transport from the hospital ☐

  If more than 15 minutes, how many? ☐

.

4. Where are your Sector Community Mental Health Team Headquarters located?

5. Was the Centre Purpose Built?

Yes ☐ No ☐ Year Service Commenced: ☐

Please provide a brief description of the premises below:

6. Are these adequate to meet the Day Centre's Service Delivery Needs?

On a scale of 1 – 5 please rate below if the Day Centres premises meet Service Needs with 1 representing not adequate and 5 representing meets service needs well

2. ☐ 2. ☐ 3. ☐ 4. ☐ 5. ☐

7. Service Users attend the Day Centre :

- Every day from Mondays to Fridays ☐
- Depends on individual Service User's needs ☐
- Hours of Opening ☐
- Is there any weekend service offered:

  Yes ☐ No ☐

.

8. What is the average daily attendance in hours at the Day Centre?

- At least (in hours)

2 ☐ 4 ☐ 6 ☐ 7 ☐ 8 ☐

9. Is there a daily meal provided for service users?

Yes ☐ No ☐

If yes, approximately what percentage of daily attendees would this be provided for? ☐

Service Concept and Diagnosis of Patients

10. List the Main Aims and Functions of the Day Centre with a scale of importance from 1 to 5 represented as follows:

1 = no importance; 2 = moderate importance; 3 = medium importance; 4 = great importance; 5 = greatest importance

_____ ☐

_____ ☐

_____ ☐

_____ ☐

_____ ☐

_____ ☐

_____ ☐

_____ ☐

_____ ☐

.

11. Does the Day Centre have any exclusion criteria?

Yes ☐ No ☐

If yes, please provide details:

Staffing & Therapeutic Activities

12. How many staff work in the Day Centre and what is their professional background? Please give the number of whole time equivalents for each professional group.

	No. of Staff	Working hours per Week
• Psychiatric Nurses		
• Psychologists		
• Occupational Therapists		
• Psychotherapists		
• Social Workers		
• Speech & Language Therapists		
• Administration (general management)		
• Secretarial		
• Other		

13. Which of the following therapeutic activities are provided in the Day Centre (Please answer Yes or No (Y/N)).

• Direct Day Structuring	

.

• Activation	
• Promoting Contacts	
• Social Skills Training	
• Training of every-day-living (eg. Cooking, household)	
• Music Therapy	
• Dance Therapy	
• Ergotherapy/occupational Therapy	
• Vocational Therapy	
• Planning of Leisure Time Activities	
• Psychological Interventions	
• Psychiatric-therapeutic talks	
• Individual Psychotherapy	
• Assessing Social Problems	
• Counselling for Social Problems e.g. Work, living, Finance	
• Counselling for Lifestyle	
• Interventions during psychiatric crisis of patients	
• Physiotherapy	
• Sporting Activities	
• Skills Development in Coping with Simple Day Structure	
• Skills development in Handling Medication	
• Skills Development in Coping with Symptoms	
• Other	

Characteristics of Service Users in 2010 & 2011

14. How many Service Users attended the Day Centre in 2010 & 2011

- Number of New Attendees 2010 ☐
- Total Number of Attendances 2010 ☐
- Number of New Attendees 2011 ☐
- Total Number of Attendances 2011 ☐
- Average No. of Daily Attendances ☐

.

15. What was the main diagnoses of Service Users in 2011 in percentage

(Categories according to ICD-10)	%
• Organic Disorders (F0)	
• Addiction, abuse (F1)	
• Schizophrenia (F20)	
• Schizo-affective disorders (F25)	
• Affective Disorders (F3)	
• Somatoform/psychosomatic disorders (F45, F54)	
• Eating / Sleeping disorders etc. (F5)	
• Personality Disorders (F6)	
• Other	

16. Who refers Service Users to the Day Centre? (in percentage).

	%
• Psychiatric Hospital (Approved Centre) / Acute Psychiatric Unit (Approved Centre)	
• Community Mental Health Services	
• Psychiatric Outpatient Service	
• Psychiatrist / Neurologist in private practice	
• Psychotherapist in Private Practice	
• General Practitioner	
• Patient herself/himself	
• Other	

Communication / Mental Health Policy

17. How would you rate the level of communication between your Day Centre and Day Hospital(s) in your area? Please tick as appropriate.

Poor ☐ Satisfactory ☐ Good ☐ Very Good ☐

Excellent ☐

18. How would you rate the level of communication between your Day Centre and Approved Centres(s) in your area? Please tick as appropriate.

Poor ☐ Satisfactory ☐ Good ☐ Very Good ☐

Excellent ☐

.

19. How would you rate the level of communication between your Day Centre and the Primary Care network in your area? Please tick as appropriate.

Poor ☐ Satisfactory ☐ Good ☐ Very Good ☐

Excellent ☐

20. How many Active Primary Care Teams are there in your local catchment area?

Number of Active Primary Care Teams: ☐

21. How do Service Users attending the Day Centre access advocacy services?

☐

22. How are Service Users involved in designing and developing services?

☐

23. A Vision For Change, Ireland's national mental health policy highlighted a lack of community based services for the delivery of high quality care and treatment services. Do you think there are adequate Day Centre places as outlined in a Vision for Change available in your Catchment Area.

Yes ☐ No ☐

.

Please provide any additional commentary you may wish to make below on Q23:

24. How does a Recovery Approach/Ethos as recommended in A Vision for Change permeate the service provision in the Day Centre ?

.

25. We are now six years into the implementation timeframe for A Vision for Change, what are the most significant changes you have seen in your Day Centre service in this six year timeframe and at this crucial juncture of the implementation period, in your opinion what are the necessary key drivers to facilitate change.

26. If you would like to provide any other commentary on Community Mental Health Services in Ireland or in particular Day Centre Service Provision your views would be most welcome.

.

I would like to take this opportunity to thank you for taking the time to complete this questionnaire, your time is very much valued and appreciated.
If you have any queries you can contact the Researcher (Marina Duffy) by e-mail at marina.duffy@mhcirl.ie or by phone on 087 9182869.

The questionnaire has been sent to you electronically for convenience and ease of return by e-mail. However, if it is your preference to complete the questionnaire by hard copy please return to the following marked strictly private and confidential and to be opened by the addressee only:-

Strictly Private & Confidential
To be Opened by the Addressee Only
Ms. Marina Duffy
Mental Health Commission
St. Martin's House
Waterloo Road
Dublin 4.
Telephone: 087 9182869 if any queries

PLEASE RETURN BY : FRIDAY 22ND JUNE 2012

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Appendix 6:

Facility Questionnaire

24 Hour (High Support) Staffed Community Residences

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Organisation / Structure

1. Description Building/Premises 24 HR Staffed Community Residence:

- Where is the building located (please tick as appropriate)

Located in same building along with other residential units ( )

Situated in a housing estate ( )

Situated within the grounds of the psychiatric hospital ( )

Private building on own ( )
Other (please specify) _____

- Description of the location of the building
  Urban( ) Periphery( ) Rural ( )

- Is the building owned by:
  Health Service Executive (HSE) ( ) Voluntary ( ) Private ( )

- <u>Building Features</u>

Interior total approx. (sqm) _____

Exterior total approx. (sqm i.e. balcony, garden, etc) _____

Number of Bedrooms:
single _____ double _____ triple _____ others _____

Number of Bathrooms: _____

Number of Bathrooms for residents use only: _____

Number of Living Rooms _____
Are there any rooms for staff use only (e.g. dressing room, bedroom, office, conference room, etc.) Yes ( ) No ( )
Is there a kitchen? Yes ( ) No ( )
Is there a designated visiting room (i.e. not TV room)? Yes ( ) No ( )
Is the building suitable for those with mobility problems? Yes ( ) No ( )
If no, what are the barriers?
_____

Number of public phones _____

.

Is there a smoking room? Yes ( ) No ( )

If yes, is it - Inside residence ( ) Outside residence ( )

2. How does the Community Residence premises meet the Service Delivery Needs?

On a scale of 1 – 5 please rate below if the Community Residence premises meet Service Needs with 1 representing not adequate and 5 representing meets service needs well

3. ☐ 2. ☐ 3. ☐ 4. ☐ 5. ☐

3. Access to Services for 24 HR Staffed Community Residence:

- Access to Services

Time in minutes to reach shopping centre or general shop on foot _____
Time in minutes to reach shopping centre or general shop by public transport _____
Time in minutes to reach post office on foot _____
Time in minutes to reach post office by public transport _____
Time in minutes to reach pub on foot _____
Time in minutes to reach primary care centre (GP) on foot _____
Time in minutes to reach primary care centre (GP) by public transport _____
Number of residents that have access to own transportation (e.g. car, bike) _____

Please enter number of individuals with particular form of transport in brackets
Personal car ( ) Bike ( ) Motorcycle ( )
Does the residence have minibus to transport residents? Yes ( ) No ( )
Is the transport shared with other residence facility? Yes ( ) No ( )
How long does it take to get to day hospital / by minibus / public transport? _____

How long does it take to get to day centre / by minibus / public transport? _____

4. Policy/System for Living in the Residence

- Do residential staff supervise daytime comings and goings of residents? Yes( ) No ( )
- Are residents allowed to leave the unit unsupervised? Yes( ) No ( )
- Do residents have a front door key? Yes( ) No ( )

.

- Can residents lock bathroom facilities? Yes( ) No ( )
- Are visiting hours scheduled? Yes( ) No ( )
- Are residents required to go to bed at a given time? Yes( ) No ( )
- Do staff run a check to make sure that residents are in their bed? Yes( ) No ( )
- Are residents required to be up at a given time?
  a) Weekdays Yes( ) No ( )
  b) Weekend, holiday and bank holiday Yes( ) No ( )
- When checking out - are residents required to notify staff where they go? Yes( ) No ( )
- Are residents required to check in at a given time? Yes( ) No ( )
- Can residents stay in their bedrooms during the day? Yes( ) No ( )
- Can residents lock their bedrooms? Yes( ) No ( )
- Are residents allowed to smoke in their bedrooms? Yes( ) No ( )
- Are there any areas where residents can be left on their own? Yes( ) No ( )
- Can residents choose whom they share their bedrooms with? Yes( ) No ( )
- Can residents choose to stay in single rooms? Yes( ) No ( )
- Do staff run a check on residents' belongings? Yes( ) No ( )
- Are residents' belongings listed? Yes( ) No ( )
- Can residents administer their own finances? Yes( ) Some ( ) No ( )

Meals

- Is the food prepared by the psychiatric hospital? Yes ( ) No ( )
- Who prepares the meals?

	Weekdays	**Weekends**
Residents	( )	( )
Staff	( )	( )
Residents and Staff	( )	( )
Kitchen Staff	( )	( )

.

- Number of residents having their main meals outside residence ( )
- Do staff have their main meals in residence? Yes( ) No ( )
- Can residents choose the menu? Yes( ) No ( )
- Can residents follow a diet? Yes( ) No ( )
- Do residents purchase/ shop for the food? Yes( ) No ( )
- Do residents have unrestricted access to the kitchen? Yes( ) No ( )

5. Staffing of Residence

- Number of daily working hours in residence ( )

- Number of staff for each scheduled shift

Hours	Nurses	Care staff	Household	Others (please specify)

- Do named core staff, staff this residence? Yes ( ) No ( )

- Do staff rotate at set intervals? Yes ( ) No ( )

- If so, is it 6 Months ( ) Yearly ( ) 2 years ( )

6. Assessment/ Admission to

- Is there a formal assessment prior to admission?

- Yes formally structured ( ) Yes but not formally structured ( ) No ( )

- How many places are there in the residence? ( )

- Are there any designated
  Respite beds ( )
  Crisis beds ( )
  Beds for other uses (please specify) _____

- Is the residence ever used to accommodate transfers from the acute unit due to bed shortages?

  Yes ( ) No ( )

- If applicable, is there a policy regarding the following admissions?

.

Respite beds Yes ( ) No ( )
Crisis beds Yes ( ) No ( )
Transfers from acute units due to bed shortages yes ( ) No ( )

- Which, if any, criteria are used as exclusion criteria?

- Acute psychotic disorders Yes( ) No ( )
  - Substance abuse (history) Yes( ) No ( )
  - Alcohol abuse Yes( ) No ( )
  - Severe physical disease Yes( ) No ( )
  - Organic brain disorder Yes( ) No ( )
  - Intellectual disability Yes( ) No ( )
  - History of violent behaviours Yes( ) No ( )
  - Former residents of psychiatric hospitals Yes( ) No ( )
  - Former residents of forensic hospital Yes( ) No ( )

- Is there a waiting list? Yes( ) No ( )

- If yes,
  Number of weeks ( )
  Number of applications ( )

- Is there a specialised rehabilitation team for the service? Yes( ) No ( )
- If so, does it have ownership of beds? Yes( ) No ( )
- If not, who has ownership of beds (please specify)?
  _____

- Who decides on the placement, discharge or transfer of patients?
- Specialised rehabilitation team Yes( ) No ( )
- Individual's care team Yes( ) No ( )
- Specialised rehabilitation team and patients own care team Yes( ) No ( )
- Other, please specify
  _____

- If there is a specialised rehabilitation team is it multidisciplinary? Yes( ) No ( )
- If so, what professionals are included:
  - Psychiatrist Yes( ) No ( )
  - Mental health nurse Yes( ) No ( )
  - Clinical psychologist Yes( ) No ( )
  - Social worker Yes( ) No ( )
  - Occupational therapist Yes( ) No ( )
  - Other
    _____

- Is there a provisional admitting diagnosis drawn up once a patient has been admitted?

Yes one week to one month ( ) Yes one to three months ( ) Yes less than three months ( )
No ( )

.

- Does each resident have an individual care & treatment plan with a clear aim?
  Yes( ) No ( )

- Does the Individual care plan include the following (please tick all appropriate boxes)

  - The specific medical treatment Yes( ) No ( )
  - The responsibilities of each member of the treatment team Yes( ) No ( )
  - Adequate documentation to justify the diagnosis Yes( ) No ( )
  - The treatment and rehabilitation activities carried out Yes( ) No ( )

- Are care plans reviewed by those responsible for the care of the resident? Yes( ) No( )

- Is there an admission form to be signed by the resident or/and family members containing details on treatment goals and residential unit process and procedures? Yes( ) No ( )

- Is there a qualified professional assigned to each resident that one can refer to throughout treatment? Yes( ) No ( )

7. Evaluation / Procedures

- Is an annual planning report compiled by the residential unit? Yes( ) No ( )

- Is there an evaluation plan underlining the 24 HR Residence's quality services and control?

  Yes( ) No ( )

  If yes please specify?

  - Performance indicators monitoring system Yes( ) No ( )
  - Clinical Evaluation of medical conditions examined by using designated evaluation tools Yes( ) No ( )
  - Surveillance of certain situations or problematic situations Yes( ) No ( )
  - Evaluating residents satisfaction Yes( ) No ( )
  - Evaluating residents' family satisfaction Yes( ) No ( )
  - Integrated Evaluation within programmes jointly coordinated with other services Yes( ) No ( )

Is there a standard clinical and psychosocial evaluation procedure to assess residents?
Yes( ) No ( )

If yes, please give details
_____

.

- Is there a procedure to take into account residents and families feedback? Yes( ) No ( )

- Is an information pack given to residents on admission (residence rules and regulations of residence, policies and procedures booklet)? Yes( ) No ( )

- Are residents given information on emergency telephone numbers? Yes( ) No ( )

- Are residents given information on rights? Yes( ) No ( )

- Are residents provided with information on the complaints procedure? Yes( ) No ( )

- Are residents told the name of the local complaints officer? Yes( ) No ( )

- Are residents informed of the Mental Health Commission (including role and function in mental health services)? Yes( ) No ( )

Characteristics of Residents

8. Profile of Residents

- Number of residents ( )

- Total men
  - 18 – 25 years ( )
  - 26 - 35 years ( )
  - 36 - 45 years ( )
  - 46 - 55 years ( )
  - 56 - 65 years ( )
  - >65 years ( )

- Total women
  - 18 – 25 years ( )
  - 26 - 35 years ( )
  - 36 - 45 years ( )
  - 46 - 55 years ( )
  - 56 - 65 years ( )
  - >65 years ( )

Number of residents that have been admitted since…

- < 6 months ( )
- 6-12 months ( )
- 13-36 months ( )
- ≥ 36 months ( )

.

Have any residents been discharged in the last 12 months? Yes( ) No ( )

Please specify where residents (number) went after discharge:
Other health unit with same level support ( )
Other health unit with lower support ( )
Hospice ( )
Family ( )
Home ( )
Other, please specify.....

- Have any residents been re-admitted after being discharged during last year?
  Yes( ) No ( )
  If yes, how many? ( )
- How many residents attend a day hospital ? ( )
- How many residents attend a day centre ? ( )
- How many residents are in full-time sheltered employment? ( )
- How many residents are in full-time supported paid employment? ( )
- How many residents are in part-time supported paid employment in the community?( )

9. What is the main diagnosis of Residents (Indicate in %)

(Categories according to ICD-10)	%
• Organic Disorders (F0)	
• Addiction, abuse (F1)	
• Schizophrenia (F20)	
• Schizo-affective disorders (F25)	
• Affective Disorders (F3)	
• Somatoform/psychosomatic disorders (F45, F54)	
•	
• Eating / Sleeping disorders etc. (F5)	
• Personality Disorders (F6)	
• Other	

How many residents have a comorbid alcohol disorder _____
How many residents have a comorbid drug dependence _____

.

10. Which of the following therapeutic activities are provided for Residents.

Please indicate the providers of the activity and where the activity occurs (*Inside residence refers to activities held in the residence. Outside residence refers to those held outside the residence). You can tick more than one box if necessary.

Activity	Provider of activity (Please tick)	Location * (please tick)
Vocational training	|__| Nurse |__| Occupational therapist |__| Social groups, volunteers, Other (specify) _____	Inside residence ( ) Outside residence ( )
Sheltered work	|__| Nurse |__| Occupational therapist |__| Social groups, volunteers, Other (specify) _____	Inside residence ( ) Outside residence ( )
Supported work in community	|__| Nurse |__| Occupational therapist |__| Social groups, volunteers, Other (specify) _____	Inside residence ( ) Outside residence ( )
Cognitive behaviour therapies	|__| Nurse |__| Occupational therapist |__| Social groups, volunteers, Other (specify) _____	Inside residence ( ) Outside residence ( )
Practical living skills	|__| Nurse |__| Occupational therapist |__| Social groups, volunteers, Other (specify) _____	Inside residence ( ) Outside residence ( )
Social skills	|__| Nurse |__| Occupational therapist |__| Social groups, volunteers, Other (specify) _____	Inside residence ( ) Outside residence ( )
Budgeting skills	|__| Nurse |__| Occupational therapist |__| Social groups, volunteers, Other (specify) _____	Inside residence ( ) Outside residence ( )
Physical activities	|__| Nurse |__| Occupational therapist |__| Social groups, volunteers, Other (specify) _____	Inside residence ( ) Outside residence ( )
Alcohol / addiction counselling	|__| Nurse |__| Occupational therapist |__| Social groups, volunteers, Other (specify) _____	Inside residence ( ) Outside residence ( )
Family education, support, counselling	|__| Nurse |__| Occupational therapist |__| Social groups, volunteers,	Inside residence ( ) Outside residence ( )

.

	Other (specify) _____	
Leisure activities	|__| Nurse |__| Occupational therapist |__| Social groups, volunteers, Other (specify) _____	Inside residence ( ) Outside residence ( )
Other (please specify, if applicable)	|__| Nurse |__| Occupational therapist |__| Social groups, volunteers, Other (specify) _____	Inside residence ( ) Outside residence ( )
Physiotherapy	|__| Physiotherapist	Inside residence ( ) Outside residence ( )

Activity	Provision	***Organiser:*** **Please tick**
To initiate activities that would involve members of the community	yes |__| no |__|	|__| Nurse |__| Occupational therapist |__| Social groups, volunteers, family Other (please specify) _____ _____
Promote participation in integrated social activities with the community	yes |__| no |__|	|__| Nurse |__| Occupational therapist |__| Social groups, volunteers, family Other (please specify) _____ _____
Promote participation in events organized by community groups	yes |__| no |__|	|__| Nurse |__| Occupational therapist |__| Social groups, volunteers, family Other (please specify) _____ _____
Facilitate residents going back to work informally to help improve social integration	yes |__| no |__|	|__| Nurse |__| Occupational therapist |__| Social groups, volunteers, family Other (please specify) _____ _____

.

Facilitate residents finding work through employment agency, regional and local enterprise agencies	yes |__| no |__|	|__| Nurse |__| Occupational therapist |__| Social groups, volunteers, family Other (please specify) _____ _____
Facilitate re-housing	yes |__| no |__|	|__| Nurse |__| Occupational therapist |__| Social groups, volunteers, family Other (please specify) _____ _____

Communication / Mental Health Policy

11. How would you rate the level of communication between your 24 HR Staffed Community Residence and Day Hospital(s)? Please tick as appropriate.

Poor ☐ Satisfactory ☐ Good ☐ Very Good ☐

Excellent ☐

12. How would you rate the level of communication between your 24 HR Staffed Community Residence and Day Centres(s)? Please tick as appropriate.

Poor ☐ Satisfactory ☐ Good ☐ Very Good ☐

Excellent ☐

13. How would you rate the level of communication between your 24 HR Community Residence and Approved Centres(s) in your area? Please tick as appropriate.

Poor ☐ Satisfactory ☐ Good ☐ Very Good ☐

Excellent ☐

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14. How would you rate the level of communication between your 24 HR Community Residence and the Primary Care network in your area? Please tick as appropriate.

Poor ☐ Satisfactory ☐ Good ☐ Very Good ☐

Excellent ☐

15. How do Residents access advocacy services?

16 How are residents involved in designing and developing services?

17. How does a Recovery Approach/Ethos as recommended in A Vision for Change permeate the service provision in the Residence ?

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18. We are now six years into the implementation timeframe for A Vision for Change, what are the most significant changes you have seen in Community Residence service provision in this six year timeframe and at this crucial juncture of the implementation period, in your opinion what are the necessary key drivers to facilitate change.

19. If you would like to provide any other commentary on Community Mental Health Services in Ireland or in particular 24 HR Community Residence Service provision your views would be most welcome.

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I would like to take this opportunity to thank you for taking the time to complete this questionnaire, your time is very much valued and appreciated.
If you have any queries you can contact the Researcher (Marina Duffy) by e-mail at marina.duffy@mhcirl.ie or by phone on 087 9182869.

The questionnaire has been sent to you electronically for convenience and ease of return by e-mail. However, if it is your preference to complete the questionnaire by hard copy please return to the following marked strictly private and confidential and to be opened by the addressee only:-

Strictly Private & Confidential
To be Opened by the Addressee Only
Ms. Marina Duffy
Mental Health Commission
St. Martin's House
Waterloo Road
Dublin 4.
Telephone: 087 9182869 if any queries

PLEASE RETURN BY : FRIDAY 14TH SEPTEMBER 2012

.

Appendix 7:

Peer Advocate Questionnaire

Day Hospital & Day Centre Community Mental Health Services

September 2012

Researcher: Marina Duffy

Telephone: 01 6362404 direct

Mobile: 087 9182869

e-mail: marina.duffy@mhcirl.ie

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I would like to take this opportunity to thank you for taking the time to complete this questionnaire, your time is very much valued and appreciated.

If you have any queries you can contact the Researcher (Marina Duffy) by e-mail at marina.duffy@mhcirl.ie or by phone on 087 9182869.

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Dublin 4.
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PLEASE RETURN BY : FRIDAY 28th SEPTEMBER 2012

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Q1: Approximately what percentage of your Advocacy work is carried out within Day Hospital settings?

%	√	**%**	√	**%**	√	**%**	√	**%**	√
10%		20%		30%		40%		50%	
60%		70%		80%		90%		100%	

0% _____ (√**)**

Q2: Approximately what percentage of your Advocacy work time is carried out within Day Centre settings?

%	√	**%**	√	**%**	√	**%**	√	**%**	√
10%		20%		30%		40%		50%	
60%		70%		80%		90%		100%	

0% _____ (√**)**

Q3: Overall, how would you rate the level of communication that exists between you, in your role as an Advocate, and the Day Hospital staff in general.

Poor ☐ Satisfactory ☐ Good ☐ Very Good ☐

Excellent ☐

* If you consider that providing an overall rate is not reflective e.g. 50% good 50% Poor, please just indicate a percentage beside the chosen rate.

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Q4: Overall, how would you rate the level of communication that exists between you, in your role as an Advocate, and Day Centre staff in general.

Poor ☐ Satisfactory ☐ Good ☐ Very Good ☐

Excellent ☐

*If you consider that providing an overall rate is not reflective e.g. 50% good 50% Poor, please just indicate a percentage beside the chosen rate.

Q5: How do Service Users attending Day Hospitals access Advocacy Services?

Q6: How do Service Users attending Day Centres access Advocacy Services?

Q7: Do you think that Advocacy Services are adequately promoted by staff in mental health community service settings to Service Users?

Yes ☐ No ☐

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Q8: How would you rate the level of involvement of Service Users in the design and development of services?

Poor ☐ Satisfactory ☐ Good ☐ Very Good ☐

Excellent ☐

Any additional commentary on Q8 above?

Q9: A Vision For Change, Ireland's national mental health policy highlighted a lack of community based services. Do you think there are adequate Day Hospital places as outlined in a Vision for Change available in your Catchment Area.

Yes ☐ No ☐

Please provide any additional commentary below on Q9 which you may wish to make.

Q10: A Vision For Change, Ireland's national mental health policy highlighted a lack of community based services. Do you think there are adequate Day Centre places as outlined in a Vision for Change available in your Catchment Area.

Yes ☐ No ☐

Please provide any additional commentary you may wish to make below on Q10.

.

Q11: On a scale of 1 – 5, in your opinion to what extent is a Recovery Approach/Ethos as recommended in a Vision for Change permeating service provision in Day Hospitals?

(1 = not adequate, 2 = adequate, 3 = good, 4 = very good, 5 = excellent)

1. ☐ 2. ☐ 3. ☐ 4. ☐ 5. ☐

Please provide any additional commentary you may wish to make below on Q11.

Q12: On a scale of 1 – 5, in your opinion to what extent is a Recovery Approach/Ethos as recommended in a Vision for Change permeating service provision in Day Centres?

(1 = not adequate, 2 = adequate, 3 = good, 4 = very good, 5 = excellent)

1. ☐ 2. ☐ 3. ☐ 4. ☐ 5. ☐

Please provide any additional commentary you may wish to make below on Q12.

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Q13: On a scale of 1 – 5, how would you rate the level of involvement of Service Users in the Care Planning Process to what extent is Individual Care Planning taking place.

(1 = not adequate, 2 = adequate, 3 = good, 4 = very good, 5 = excellent)

1. ☐ 2. ☐ 3. ☐ 4. ☐ 5. ☐

Please provide any additional commentary you may wish to make below on Q13.

Q14: We are now six years into the implementation timeframe for A Vision for Change, what are the most significant changes you have seen in Day Hospital service provision in this six year timeframe.

Q15: We are now six years into the implementation timeframe for A Vision for Change, what are the most significant changes you have seen in Day Centre service provision in this six year timeframe.

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Q16: At this crucial juncture of the policy implementation period, in your opinion what are the necessary key drivers to facilitate change

Q17: If you would like to provide an additional commentary on Community Mental Health Services in Ireland your views would be most welcome.

I would like to take this opportunity to thank you for taking the time to complete this questionnaire, your time is very much valued and appreciated. If you have any queries you can contact the Researcher (Marina Duffy) by e-mail at marina.duffy@mhcirl.ie or by phone on 087 9182869.

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PLEASE RETURN BY : FRIDAY 28th SEPTEMBER 2012

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Appendix 8 :

Day Centre (Aims & Functions)

Rated 5:	
Offer an early point of access	5
Provide an integrated comprehensive quality assured individualized system of care and support, responsive to the needs of the individual in the community.	5
Empower clients to take responsibility for his or her recovery in a inclusive service	5
Enable clients to feel safe, supported listened and understood	5
Monitoring the client's medication, therapies and care needs.	5
Ordering, collecting, storage of medication	5
Medication management programme	5
Personal hygiene programme	5
Lunch and evening tea	5
Rehab and recovery team input, CNS involvement	5
Socialisation	5
Activation	5
Monitoring mental state	5
Assessment and care planning with client signing their care programme	5
Crisis planning / contingency planning for unscheduled presentations	5
Early intervention, identification of relapse signature and relapse prevention strategies.	5
Interfacing with General Practitioners and other primary care disciplines	5
Ensure an empowering approach. Which encompasses service users and service provider	5
Promote recovery and independence.	5
Develop skills for activities of daily living.	5
Rehabilitation	5
Recovery	5

.

Client empowerment	5
Faster independence.	5
Engagement in the wide community	5
Daily living skills	5
Patient central philosophy	5
Therapeutic assessment/ interventions.	5
To empower , educate and support service users on their journey to recovery	5
To encourage meaningful activity to include education and skills development.	5
Peer support and social integration	5
Individual safety needs	5
Empowerment	5
Skills development	5
Offer a client centered service based on recovery	5
Promote existing strengths and assist client in mew skills	5
Liaise with MDT members to provide comprehensive service.	5
Liaise with services in primary care to provide holistic approach	5
Provide therapeutic activities	5
Relapse prevention	5
Empowerment	5
Skills Development	5
To provide assessment of each individuals physical and psychological needs and to provide a realistic programme designed to assist service users to reach their potential , however wide or limited that maybe	5
Crisis intervention	5
Relapse prevention	5
1 to 1 psychotherapy	5

.

Independent living (supportive)	5
Individualised care planning	5
Social interaction / support	5
Clinical assessments (OPD)	5
Promote social skills and independence	5
Promote compliance of medication	5
Develop coping skills	5
Develop skills in dealing with symptoms	5
Promote daily activation	5
Integration in society	5
Monitoring mental health	5
Medication supervision	5
Socialisation	5
Structure to day	5
Manage their illness	5
Providing activation and rehabilitation programmes	5
Anxiety management	5
Relaxation	5
Preparation for work/training	5
Support for service users	5
Support for families	5
Monitor wellness	5
Anxiety management 1:1	5
Support network	5
Medication supervision for some	5
Observation / maintain wellbeing	5
Maintaining normal life contact/routine when attending centre.	5

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	Flexibility to meet individual client needs/group needs.	5
	Socialisation	5
	Staff endeavour to provide a therapeutic service to people with mental health needs	5
	Centre have their special needs indentified and nurtured in a warm flexible and unconditional atmosphere.	5
	To promote atmosphere and empower the individual to cope with life's difficulties	5
	To provide a quality training service in all areas of life's activities.	5
	To teach new skills maintain level of progress and seek to improve i.e. concentration motivation levels etc. thus enhancing quality of life	5
	To develop individual care plan to help overcome or minimize problems and improve social and psychological functioning	5
	There by enabling clients to return to a socially valued lifestyle.	5
	Educational programmes are structured with emphasis in informal and formal techniques relative to clients special needs.	5
	Programmes are client – centred with a holistic approach	5
	Unit recognizes responds and respects the rights of each individual to strive to achieve their full potential through a wide range of support relative to their needs	5
	Ongoing assessment and support of mental health	5
	Social interaction combining loneliness and isolation.	5
	Continued social engagement with public-other services.	5

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Rated 4:	
Good communication with service users, family, next of kin and all relevant persons	4
Rehabilitation programmes / resocialisiation use of recovery model in progress.	4
Clients to for discharge if possible	4
Provide an ongoing support to relatives, hostel staff (there are two hostels whose clients afford this service	4
As part of MDT functionary and to provide clinical support to “?” training facility which is located next door.	4
Mood monitoring, Psychiatric reviews, SHO reviews.	4
Liaising with local GP’s and pharmacies re client care.	4
Medication Monitoring	4
Art Therapy	4
Social Skills Training	4
Monitoring response and tolerability to treatment	4
Medication Management	4
Problem solving / solution focused	4
Developing close ties with voluntary and statutory agencies	4
Promote a consistent, responsive and timely service	4
Continuous quality improvement	4
Open Culture	4
Appropriate care in the appropriate area	4
Promote self esteem	4
Provide mental health education	4
Early intervention preventing full relapse if illness	5/4
To provide a holistic approach which looks at biological psychological and social need	4
To provide a structure to the day which is flexible and responsive to	4

.

peoples changing needs	
General supportive counselling	4
To encourage personal responsibility and good planning.	4
To promote problem solving and symptom reduction	4
Support families of clients.	4
Educational programmes	4
To establish acceptable social habit and behaviours	4
Coping with symptoms group therapy	4
Promotion of health living	4
Day activities programme	4
Active community participation	4
Counselling for social problems	4
Assist with active of daily living	4
Assessment and diagnosis – support	4
Present admission to acute unit and a step down facility available for post discharge client.	4
Rehabilitation	4
Socialising	4
Education regarding managing mental health	4
Social integration	4
Life skills	4
Promote social integration	4
Health education and promotion	4
Social Skills	4
Community living skills	4
Socialisation	4
Motivation	**4**

.

Counselling	4
Hot meal, showers/personal hygiene	4
Activities at centre, VEC and NLN	4
Medication admission education, side effects monitoring.	4
Assistance with ADL's / self administration /provision of hot meals	4

Rated 3:	
Money Management programme	3
Social space, social outings.	3
Art, reflexology, dance voice and movement, solutions for wellness	3
Cookery	3
Social integration provide links with community employment and education schemes	3
Liaising and networking with agencies and other services.	3
Education and training	3
Leisure interests	3
Basic needs – personal hygiene washing clothes etc.	3
Psycho education	3
Psychiatric observation on improvement/deterioration of mental health	3

Rated 2:	
Computer skills	2
Having a mental health professional to talk to.	2

Rated 1:	
Active participation in planning groups / art/social activities	1

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Other:	
To be a conduit in attaining optimum mental well being, delivered in a dignified and courteous manner.	
Always reflective of client needs, always cognisant of best practice, always willing to listen, always willing to change.	

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Appendix 9:

Codebook for Day Hospital Returns

Description of Variable	SPSS Variable Name	Coding Instructions
Identification Number	Id	Subject Identification Number
Q1 Are Number of places fixed	Q1fixed	0 = no, 1 = yes
Q1 Number of places	Q1 places	
Q2 Catchment area Population	Q2 pop	
Q2 CA Type	Q2 CA Type	1 = rural, 2 = small town, 3 = large town, 4 = city
Q2 % unemployment	Q2 % unemp 2011	%
Q2 Number of DH in local CA	Q2 DH in CA	
Q2 Number of ACs in local CA	Q2 AC in CA	
Q2 Total no. Of beds	Q2 bed nos	
Q3 Location of DH	Q2 Location	1 = inside hospital building, 2 = on hospital grounds, 3 = next to the hospital grounds, 4 = within 15 mins from hospital by public transport, 5 = more than 15 minutes by public transport
Q3 Location more than 15 mins by PT	Q3 >15 mins by PT	
Q4 Location of Sector team headquarters	Q4 ST Location	
Q5 Was DH purpose built	Q5 DH PB	1 = yes, 2 = no
Q5 Year service commenced	Q5 YSC	
Q5 Description of premises	Q5 Description	
Q6 DH Meeting Service Needs	Q6 DH SN	1 = not adequate, 5 = Meets Service needs well
Q7 Access to CH in LCA	Q7 Access to CH	1 = Yes, 2 = no
Q7 plans to establish CH	Q7 Plans for CH?	1 = Yes, 2 = no
Q8 SU attend DH	Q8 Attendance	1 = Mon to Fri, 2 = depends on patients needs, 3 = if necessary at weekends, 4 = obligatory at weekends too
Q8 Hours of opening	Q8 H of O	
Q9 Minimum time	Q9 MT	1 = Yes, 2 = No
Q9 SU attend in hours	Q8 Hrs attend	2, 4, 6, 7, 8 or other
Q10 Aims and functions – shorten inpatient treatment	Q10 shorten Inp Treat	1 = no imp, 2 = mod imp, 3 = medium imp, 4 = great import, 5 = greatest import
Q10 Alternative to Inp Treat	Q10 Alt to Inp Tre	1 = no imp, 2 = mod imp, 3 = medium imp, 4 = great import, 5 = greatest import
Q10 Used for Outpatient clinics	Q10 used for OPCs	1 = no imp, 2 = mod imp, 3 = medium imp, 4 = great import, 5 = greatest import
Q10 Addition to OPCs	Q10 Addit to OPCs	1 = no imp, 2 = mod imp, 3 = medium imp, 4 = great import, 5 = greatest import
Q10 Crisis Intervention	Q10 CI	1 = no imp, 2 = mod imp, 3 =

.

		medium imp, 4 = great import, 5 = greatest import
Q10 Psychotherapy	Q10 Psychotherapy	1 = no imp, 2 = mod imp, 3 = medium imp, 4 = great import, 5 = greatest import
Q10 Rehab for chronic disorders	Q10 Rehab for CDs	1 = no imp, 2 = mod imp, 3 = medium imp, 4 = great import, 5 = greatest import
Q10 Social Rehab and Support	Q10 Soc Reh & Supp	1 = no imp, 2 = mod imp, 3 = medium imp, 4 = great import, 5 = greatest import
Q10 Other	Other	1 = no imp, 2 = mod imp, 3 = medium imp, 4 = great import, 5 = greatest import
Q11 Exclusion Criteria for DH	Q11 EC for DH	1 = too long a distance from DH, 2 = does not have own accomm, 3 = no motivation, 4 = Acute psychotic decompensation, 5 = Acute suicidal ideation, 6 = ID, 7 = Drug Addic/Abuse, 8 = Organ Disorders, 9 = Other
Q12 Diagnostic Procedures	Q12 Diag Proced	1 = Psychological tests, 2 = blood tests, 3 = urine tests, 4 = physical examination, 5 = neurological examination, 6 = interviews with relatives, collateral history, 7 = others
Q13 No. of Staff	Q13 No. of Staff	1 = Psychiatrists, 2 = PNs, 3 = Psychols, 4 = OTs, 5 = Psychother, 6 = SWs, 7 = S&LT, 8 = Admin (Management), 9 = Secretarial, 1= Other
Q13 Hours PW of Staff	Q13 Hours PW of Staff	1 = Psychiatrists, 2 = PNs, 3 = Psychols, 4 = OTs, 5 = Psychother, 6 = SWs, 7 = S&LT, 8 = Admin (Management), 9 = Secretarial, 1= Other
Q14 Activities provided in DH	Q14 DH Activities	1 = Direct Day Structuring, 2= Activation, 3= Promoting Contacts, 4 = Social Skills Training, 5 = Everyday living (cooking, household), 6 = Music Therapy, 7 = Dance Therapy, 8 = Ergotherapy/OT, 9 = Vocational Therapy, 10 = Planning of Leisure Activities, 11 = Psychiatric Nursing Activities, 12 = Psychological Interventions, 13 = Psychiatric Therapeutic Talks, 14 = Individual Pschotherapy, 15 = Biological-psychiatric interventions, 16 = Interventions by Somatic specialists, 17 = Assessing Social

.

		Problems, 18 = Counselling for Social Problems e.g. work, living, finance, 19 = Counselling for Lifestyle, 20 = interventions during psychiatric crisis of patients, 21 = outreach activities (e.g. home visits, if patients to not attend DH), 22 = Physiotherapy, 23 = Sporting Activities, 24 = Coping with simple day structure, 25 = Coping with Symptoms, 26 = Other
Q15 Attendances at DH - new attendees 2010	Q15 new attendees 2010	
Q15 Total number of attendances 2010	Q15 Total number of attendances 2010	
Q15 New Attendees 2011	Q15 new attendees 2011	
Q15 Total number of attendances 2011	Q15 Total number of attendances 2011	
Q15 Average daily attendance	Q15 ADA	
Q16 %Diagnoses of SUs 2011	Q16 %DiagSU2011	1 = Organic Disorders, 2 = Addiction Abuse, 3 = Schizophrenia, 4 = Schizo-affective disorders, 5 = Affective Disorders, 6 = Somatoform/psychosomatic disorders, 7 = Eating / Sleeping disorders, 8 = Personality Disorders, 9 = Other
Q17 Who Referred to DH in 2011 in %	Q17 Who refers 2011 %	1 = Psychiatric Hospital or Unit (Approved Centre), 2 = Community Mental Health Services, 3 = Psychiatric Outpatient Service, 4 = Psychiatrist / Neurologist in Private Practice, 5 = Psychotherapist in Private Practice, 6 = General Practitioner, 7 = Patient himself/herself, 8 = Other
Q18 Comm MH Policy Rate of Comm between DH and AC	Q18 Comm DH & AP	1 = Poor, 2 = Satisfactory, 3 = Good, 4 = Very Good, 5 = Excellent
Q19 Comm MH Policy Rate of Comm between DH and PC	Q19 Comm DH & PC	1 = Poor, 2 = Satisfactory, 3 = Good, 4 = Very Good, 5 = Excellent
Q20 Is there an overlap between services provided by DH and PCCentres	Q20 Overlap DH & PCC	
Q21 No of Active PC Teams in Local catchment area	Q21 No. of PC Teams in LCA	
Q22 Do they complement work of DH?	Q22 complement work of DH	
Q22 Commentary on above	Q22 Commentary	
Q23 How do SU access Advocacy Services	Q23 SUs access Advocacy Services	

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Q24 Are SUs involved in designing and developing services	Q24 SUs designing and developing services	
Q25 Do all SUs of DH have an individual Care and treatment Plan	Q25 Do SUs have an ICP	1 = Yes, 2 = No
Q25 ICP commentary	Q25 ICP commentary	
Q26 In line with VFC are there adequate DH places in CA	Q26 adequate DH places in CA	1 = Yes, 2 = No
Q26 commentary	Q26 commentary	
Q27 Are there sufficient DH places for specialist services Rehabilitation and Later life	Q27 Sufficient DH places for Specialist services	1 = Yes, 2 = No
Q27 Commentary	Q27 Commentary	
Q28 How does a Recovery Approach/ethos as per AVFC permeate DH service provision	Q28 Recovery permeate SP in DH	
Q29 Significant changes for DH since VFC and key drivers for change	Q29 Significant changes for DH since VFC and key drivers for change	
Q30 Any additional commentary on CMHS in Ireland	Q30 Any additional commentary on CMHS in Ireland	

.

Appendix 10:

Codebook for Day Centre Returns

Description of Variable	SPSS Variable Name	Coding Instructions
Identification Number	Id	Subject Identification Number
Q1 Are Number of places fixed	Q1fixed	0 = no, 1 = yes
Q1 Number of places	Q1 places	
Q2 Catchment area Population	Q2 pop	
Q2 CA Type	Q2 CA Type	1 = rural, 2 = small town, 3 = large town, 4 = city, 5 = combination urban, suburban and rural
Q2 % unemployment	Q2 % unemp 2011	%
Q2 Number of DC in local CA	Q2 DC in CA	
Q2 Number of ACs in local CA	Q2 AC in CA	
Q2 Total no. Of beds	Q2 bed nos	
Q3 Location of DH	Q2 Location	1 = inside hospital building, 2 = on hospital grounds, 3 = next to the hospital grounds, 4 = within 15 mins from hospital by public transport, 5 = more than 15 minutes by public transport
Q3 Location more than 15 mins by PT	Q3 >15 mins by PT	
Q4 Location of Sector team headquarters	Q4 ST Location	
Q5 Was DC purpose built	Q5 DC PB	1 = yes, 2 = no
Q5 Year service commenced	Q5 YSC	
Q5 Description of premises	Q5 Description	
Q6 DC Meeting Service Needs	Q6 DC SN	1 = not adequate, 2 = moderately adequate, 3 = adequate, 4= Meets service needs, 5 = Meets Service needs well
Q7 SU attend DC	Q7 Attendance	1 = Mon to Fri, 2 = depends on SUs needs,
Q7 Hours of opening	Q7 H of O	1 = 9 to 5, 2 = other
Q7 DC Weekend Service	Q7 DC WS	1 = Yes, 2 = No
Q8 Average SU attend in hours	Q8 Hrs attend	1 = 2, 2 = 4, 3 = 5, 4 = 6, 5 = 7, 6 = 8
Q9 Daily Meal	Q9 Provision of meal	1 = Yes, 2 = no
Q9 Daily Meal number	Q9 How many meals	%
Q10 Aims and functions	Q10	
Q10 Aims & Functions	Q10	
Q10 Aims & Functions	Q10	
Q10 Aims & Functions	Q10	
Q10 Aims & Functions	Q10	
Q10 Aims & Functions	Q10	
Q10 Aims & functions	Q10	
Q10 Aims & functions	Q10	
Q10 Other	Other	
Q11 Exclusion Criteria for DC	Q11 EC for DC	1 = Yes, 2 = No
Q11 Exclusion Criteria for DC	Q11 EC for DC	

.

Q12 No. of Staff	Q12 No. of Staff	Line for each
Q12 Hours PW of Staff	Q12 Hours PW of Staff	Line for each
Q13 Activities provided in DC	Q13 DC Activities	1 = Direct Day Structuring, 2= Activation, 3= Promoting Contacts, 4 = Social Skills Training, 5 = Everyday living (cooking, household), 6 = Music Therapy, 7 = Dance Therapy, 8 = Ergotherapy/OT, 9 = Vocational Therapy, 10 = Planning of Leisure Activities, 11 = Psychiatric Nursing Activities, 12 = Psychological Interventions, 13 = Psychiatric Therapeutic Talks, 14 = Individual Pschotherapy, 15 = Biological-psychiatric interventions, 16 = Interventions by Somatic specialists, 17 = Assessing Social Problems, 18 = Counselling for Social Problems e.g. work, living, finance, 19 = Counselling for Lifestyle, 20 = interventions during psychiatric crisis of patients, 21 = outreach activities (e.g. home visits, if patients to not attend DH), 22 = Physiotherapy, 23 = Sporting Activities, 24 = Coping with simple day structure, 25 = Coping with Sympstoms, 26 = Other Line for each Y/N
Q14 Attendances at DC - new attendees 2010	Q15 new attendees 2010	
Q14 Total number of attendances 2010	Q15 Total number of attendances 2010	
Q14 New Attendees 2011	Q15 new attendees 2011	
Q14 Total number of attendances 2011	Q15 Total number of attendances 2011	
Q14 Average daily attendance	Q15 ADA	
Q15 %Diagnoses of SUs 2011	Q16 %DiagSU2011	1 = Organic Disorders, 2 = Addiction Abuse, 3 = Schizophrenia, 4 = Schizo-affective disorders, 5 = Affective Disorders, 6 = Somatoform/psychosomatic disorders, 7 = Eating / Sleeping disorders, 8 = Personality Disorders, 9 = Other
Q16 Who Referred to DC in 2011 in %	Q17 Who refers 2011 %	1 = Psychiatric Hospital or Unit (Approved Centre), 2 = Community Mental Health Services, 3 = Psychiatric Outpatient Service, 4 = Psychiatrist / Neurologist in Private Practice, 5 = Psychotherapist in

.

		Private Practice, 6 = General Practitioner, 7 = Patient himself/herself, 8 = Other
Q17 Comm MH Policy Rate of Comm between DC and DH	Q18 Comm DC & DH	1 = Poor, 2 = Satisfactory, 3 = Good, 4 = Very Good, 5 = Excellent
Q18 Comm MH Policy Rate of Comm between DC and AC	Q19 Comm DC & AC	1 = Poor, 2 = Satisfactory, 3 = Good, 4 = Very Good, 5 = Excellent
Q19 Comm MH Policy Rate of Comm between DC and PC	Q19 Comm DC & PC	1 = Poor, 2 = Satisfactory, 3 = Good, 4 = Very Good, 5 = Excellent
Q20 No of Active PC Teams in Local catchment area	Q20 No. of PC Teams in LCA	
Q21 How do SU access Advocacy Services	Q21 SUs access Advocacy Services	
Q22 Are SUs involved in designing and developing services	Q22 SUs designing and developing services	
Q23 In line with VFC are there adequate DC places in CA	Q23 adequate DC places in CA	1 = Yes, 2 = No
Q23 commentary	Q23 commentary	
Q24 How does a Recovery Approach/ethos as per AVFC permeate DC service provision	Q24 Recovery permeate SP in DC	
Q25 Significant changes for DC since VFC and key drivers for change	Q25 Significant changes for DC since VFC and key drivers for change	
Q26 Any additional commentary on CMHS in Ireland	Q26 Any additional commentary on CMHS in Ireland	